

# ANNUAL SYSTEM OF CARE

## STATUS REPORT

for

## COMMUNITY COLLABORATIVES

Connecticut Community KidCare

**Department of Children and Families**

**DIVISION OF MENTAL HEALTH**



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Commissioner**

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## INTRODUCTION

The Department of Children and Families (DCF), in conjunction with the Children's Behavioral Health Advisory Committee (CBHAC), assessed Connecticut's local Community Collaboratives. The tools used for this assessment, a Community Collaborative Member Survey and a Parent Survey, with mostly open-ended questions (Appendix 1 & 2), reflect updates based upon the evolution of the Connecticut Community KidCare (KidCare) initiative and the System of Care approach to revamp the children's behavioral health service delivery system.

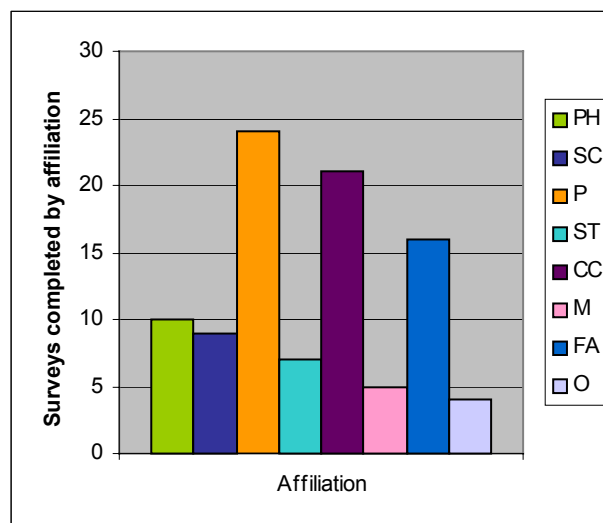
Parents, Regional Systems Coordinators, Family Advocates, Care Coordinators, and other members from all the Community Collaborative's Community Resource Committee (CRC) were asked to complete the surveys, detailing the functioning, progress and areas of improvement for each local Community Collaborative. Each collaborative was asked to submit 6 surveys, for a statewide total of approximately 150 responses. Ninety-six (96)<sup>1</sup> Community Collaborative Member Surveys and twenty-seven (27) Parent surveys were returned and analyzed to inform this report. This year's returns mark an increase of 34 surveys over last year's receipt rate, but far short the expected number of 150 surveys. Figure 1 and Table 1 illustrate the constellation of survey respondents. Appendix 3 contains a breakdown of survey respondents by Community Collaborative.

Table 1. Survey Respondent Percentages

Type	# Respondents	%
PH	10	10%
SC	9	9%
P	24	25%
ST	7	7%
CC	21	22%
M	5	5%
FA	16	17%
O	4	4%
<b>Total</b>	<b>96</b>	<b>100%</b>

PH= Parent  
SC= Systems Coordinator  
ST= State Agency  
M= Municipality  
FA= Family Advocate  
P= Provider  
O=Other  
CC= Care Coordinator

Figure 1. Survey Respondent Percentages



Survey responses were combined with other information, including observations made by mental health experts, to create this fifth annual report, prepared in response to Public Acts 97-272 and 00-188. This fifth edition of the annual System of Care Status Report, outlines the tremendous progress that the State's twenty-six (26) Community Collaboratives have made over the past few years and proffers critical next steps that these consortiums must undertake in order to successfully support the infrastructure developing under the Department of Children and Families' Connecticut Community KidCare initiative, the children's service system with the CT Behavioral Health Partnership (CTBHP).

## HISTORY OF SYSTEMS OF CARE

Nationally, the children's behavioral system has been identified as an area of concern for over 30 years. Special committees have been convened, complemented by seminal documents articulating the problems and needed solutions to improve the quality of service to children with serious emotional disturbances

<sup>1</sup> Seven (7) serves were received too late to be included in the analysis. Thus, while 103 surveys were eventually returned, only 96 were received in sufficient time to be analyzed.

(SED). During the early to mid-1980's, the vision for effective children's mental health service delivery took more complete shape. Informed by Jane Knitzer's authoring of "Unclaimed Children," which outlined the inadequacies of the nation's approach to children's mental health services, a sustained, critical review of the children's behavioral health delivery system and the role of families within that system began to occur.

Concomitant with the new focus on children's mental health, a model system of care approach to serving children with challenging behavioral health care needs emerged. Modest federal funding became available in 1984 to launch the Child and Adolescent Service System Program (CASSP). Through CASSP, states and communities were awarded funds to develop coordinated systems of care for children with SED. In the 1986 monograph titled "A system of care for children with severe emotional disturbances," authors Beth A. Stroul and Robert Friedman articulated accessible and replicable principles, values and a philosophical framework in which to "build services that would allow children with emotional disturbances to remain in their home and communities."

Three years later, the system-defining tome, "Towards a Culturally Competent System of Care Volume 1: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed" was developed. Terry Cross, Barbara J. Bazron, Karl Denis, and Maressa Issacs prepared this monograph to aid communities in effectively addressing and meeting the needs of culturally diverse children and families receiving services within the system of care model. This document, as well as Stroul and Friedman's publication, continue to serve as important primers in defining the conceptual matrices that form effective community-based behavioral health care for children.

From these beginnings, a nationally embraced movement to create comprehensive, coordinated, culturally – competent, interagency collaborations to effect each state's and communities' children's mental health agenda has developed. Connecticut, joining with fellow states, has adopted the systems of care approach in modeling its service system for children's behavioral health. For nearly a decade, families, providers, state agencies, and other key stakeholders have formed voluntary consortium to create singular, local strategies to better serve children who have traditionally been served in restrictive, out-of-community settings. At present, there are 27 Community Collaboratives (formerly known as System of Care Collaboratives) that have served over 400 children during FFY 2002, using the nationally delineated systems of care models.

## **THE FEDERAL AND STATE SYSTEMS OF CARE MODEL**

The federal Center for Mental Health Services (CMHS) defines a System of Care as follows:

A comprehensive spectrum of mental health and other support services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with serious emotional disturbances and their families. The creation of such System of Care involves a multi-agency, public/private approach to delivering services, an array of service options, and flexibility to meet the full range of needs of children, and their families. Mechanisms for managing, coordinating, and funding services are necessary.

Under the Connecticut Community KidCare reform, System of Care Community Collaboratives are defined as:

*A local consortium of public and private health care providers, parents and guardians of children with behavioral health needs and service and education agencies that have organized to develop coordinated comprehensive community resources for children or youth with complex*

*behavioral health service needs and their families in accordance with principles and goals of Connecticut Community KidCare.*

As the above definitions note, System of Care Community Collaboratives are predicated upon diverse, non-categorical<sup>2</sup>, community-based partnerships. In a System of Care, local communities provide coordinated, comprehensive services through a partnership of families, private providers, local and state agencies, and community members. These voluntary consortiums retain responsibility for service planning and assist the families and children in their geographical area. In the community of mental health professionals, there is consensus that children are best served as members of families and that families are an integral part of local communities, and central to effective service planning and delivery. It is also recognized that, when clinically appropriate, children with serious emotional disturbance are best served when treatment is local and community based. Accordingly, the System of Care is guided by a number of guiding principles:

- Emotionally disturbed children should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
- Children with emotional disturbances should receive services tailored to the unique needs and potential of each child and guided by an individualized service plan.
- Children should receive services in the least restrictive, most normative environment that is clinically appropriate.
- The children's families and surrogate families should participate fully in the planning and delivery of services.
- The services offered to emotionally disturbed children should be integrated. The various agencies and programs involved should be able to coordinate and their efforts.
- Case management should be available to ensure that services are coordinated and delivered in a therapeutic manner and that children can proceed through the system in accordance with their changing needs.
- The system should promote early identification and intervention for children with emotional problems to increase the likelihood of positive outcomes.
- The system should protect the rights of emotionally disturbed children and should promote effective advocacy for them.
- Children should receive services without regard to race, religion, national origin, gender, physical disability, or other defining characteristic. Services should be sensitive and responsive to cultural differences and special needs.

**Figure 2. System of Care Core Values**

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- **Child Centered:** The needs of the child and family should dictate the mix of services provided
  - **Community-Based:** Managed at the community level, where services are planned and rendered
  - **Culturally Competent:** Agencies and programs should respond to the cultural, racial and ethnic differences of the populations they serve

The children who reach the Community Collaboratives have serious, complex, and challenging problems, typically recognized as requiring intensive, "Level III Care Coordination."<sup>3</sup> While the local Community Collaboratives have taken creative approaches to problem solving, and agencies with funding for fixed categories of services have shown flexibility, the children and their families often have unique needs that

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<sup>2</sup> Building Systems of Care: A Primer – S.Pires (2002)

<sup>3</sup> Pursuant to the Practice Standards for the Systems of Care, there are three levels of care coordination. Those children, who receive the full services of the Community Collaboratives, specifically intensive Care Coordination and Family Advocacy, are identified as being at Level III.

defy existing service formats. These children and their families require a broad menu of services—a wraparound model—tailored to suit their individual needs.

### **Wraparound and Flexible Funding**

The term “wraparound” denotes “a philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes” (SAMSHA, 1999, p. 173). The “framing elements” of the wraparound process, as set forth by the Center for Effective Collaboration and Practice (CECP) are as follows:

1. Wraparound efforts must be based in the community
2. Services and supports must be individualized to meet the needs of children and families
3. The process must be culturally competent and build on the unique values, preferences, [and] strengths of children and families
4. Parents must be included in every level of development of the process
5. Agencies must have access to flexible, non-categorical funding
6. The process must be implemented on an inter-agency basis and be owned by the larger community
7. Wraparound plans must include a balance of formal services and informal community and family resources
8. Services must be unconditional. If the needs of the child and family change, the child and family are not to be rejected from services. Instead, the services must be changed.
9. Outcomes must be measured.

The wraparound approach has proven effective in apparently intractable situations where there seemed to be no alternative to expensive out-of-home and community placement. (Burns & Goldman, 1999; VanDenBerg & Grealish, 1996) As the above elemental tenets evidence, in order for the wraparound approach to be actualized, participants must have access to discretionary funds. These discretionary funds, commonly referred to as “flexible funds,” allow for creative, strength-based, culturally competent, cost-efficient alternatives to placement. This alternative care includes services such as in-home supports, additional respite for family members, mentoring, therapeutic recreation, tutoring and behavioral coaching.

The KidCare initiative and the operationalization of the Systems of Care model, are congruent with the wraparound philosophy. Similar to wraparound, KidCare through the Collaboratives embrace the community-based treatment that occurs through a mix of clinical and complementary supports and remains cognizant of the integral role of the family within service provision. As various sections of this document evidence, the Community Collaboratives have championed the wraparound approach and have undertaken a variety of initiatives and practices to support individualized servicing for children with SED and their families. Recognizing the vital importance of the wraparound approach in creating positive outcomes for children with complex behavioral health care needs, a number of Collaboratives have independently sought funding to purchase services that complement clinical treatment and identify access to flexible funding as an essential need.

Presently, services within the Systems of Care Community Collaborative approach come from a variety of sources: state funded contracts, foundation grants, federal funds and insurance reimbursement. Recently, contracts have been executed with 6 Community Collaboratives, providing them with flexible funding for children and their families through state Strategic Investment Board dollars. This pilot funding is critical to the System of Care Collaboratives and will allow them to offer a true, individualized, wraparound service approach. In addition, funds from the Federal Mental Health Block Grant have been earmarked to provide limited flexible funding to aid other Community Collaboratives so that they can holistically meeting the needs of children with complex behavioral health care needs.

State and Federal Fiscal Year 2003 will mark the first time in which flexible funding has been more broadly available to the Community Collaboratives. During SFY 2001 and FFY 2002 a number of Collaboratives, as in year's past, have sought flexible funding through private foundations and devised creative solutions to accommodate a child's individual needs. This year, many survey respondents identified access to flexible, non-categorical funds as a top need of their Collaboratives. As the surveys and national literature indicate, the availability of flexible funds is an essential resource in supporting the Collaboratives in their duties of maintaining children with SED in their homes and communities.

In addition to creative and flexible usages of existing services, some Collaboratives have secured financial support from city governments or local educational authorities (e.g., Milford, West Haven, adjacent towns in the Lower Naugatuck Valley, and six shoreline towns adjacent to Branford). Collaboratives have also used discretionary dollars to fund non-traditional services for clients with "special" needs that cannot be addressed by usual categorical services. Some DCF regions have made available small amounts of discretionary funds, requiring a local match, for System of Care clients. Also, some collaboratives use membership dues to create a small pool of flexible funding (e.g., Middlesex CASSP and New Haven).

Routine access to flexible, non-categorical funds will continue to be important. While dramatic changes in Connecticut's behavioral system, which had in the past predicated enhanced mental health programming on DCF involvement (e.g., Protective Services or Voluntary), have occurred to expand service access; flexible funding are a vital resource that must be readily available to all children and youth served through the Community Collaboratives. Sustainable mechanisms to accomplish this task are necessary. Technical assistance and staff support to the Community Collaboratives to aid in their seeking of foundation and grant funds to cull pools of flexible funding are key strategic elements that will need to be extended to facilitate this action.

### **Connecticut Community Collaborative Structure**

A local Community Collaborative ("Collaborative") comprises one or more contiguous towns or cities holding a common vision for children's emotional, behavioral, and educational needs. A fully operational and integrated Collaborative involves many constituents. Well-rounded Collaboratives include membership of behavioral providers, parents, schools, municipalities, state agencies, faith organizations, the business community and non-traditional agencies.

Ideally, there is a comprehensive, coordinated array of services that are implemented in conformance with the shared vision and values articulated in the Connecticut's Children's Mental Health Plan. Members of a Community Collaborative commit their time to planning and developing the service system. In addition, parents of children with serious emotional disturbances are involved at each level of planning and decision-making, with the needs of the child being served determining the composition of individualized, Child-Specific Teams.

As Tables 2 and 3 below indicates, the Collaboratives continue to mature and expand the constellation of participating members. In comparison to last year, notable positive changes include that 13% more of the Collaboratives report participation from local schools systems and an impressive 41% more of them report parent membership. Concerning; however, there was a 14% drop in the number of Collaboratives that report participation from agencies specializing in substance abuse services. This drop will need to be reviewed by the Collaboratives in conjunction with their Regional DCF Systems Coordinator to make outreach to substance abuse service providers to ensure their continued participation on all the local Community Collaboratives.

**Table 2. Percentage of Select Community Collaborative Membership**

Juvenile Justice	Education	Early Childhood	Substance Abuse	Hospitals	Housing	Adult Mental Health	Private Insurance
46%	92%	58%	42%	67%	8%	54%	13%

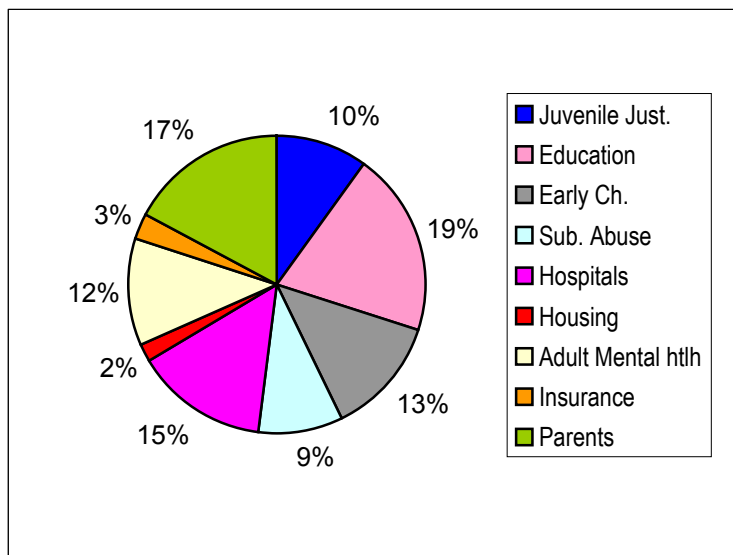


Figure 4. Community Collaborative Membership by Percentage

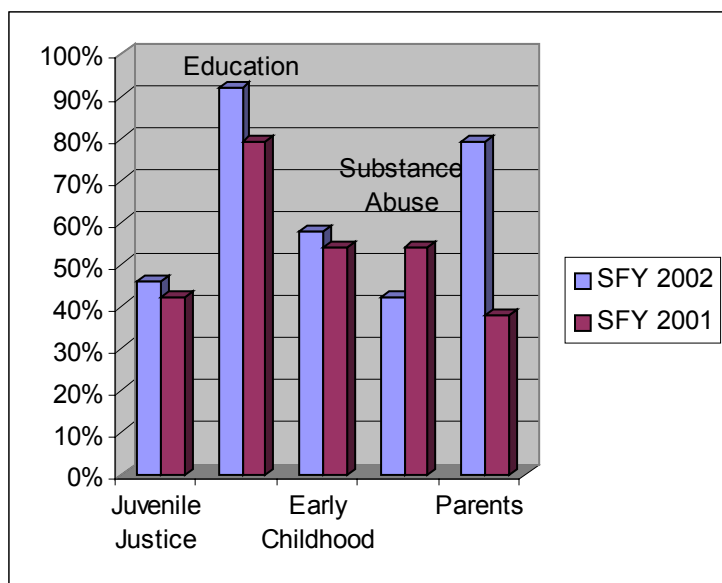


Figure 5. SFY 01 and SFY 02 Community Collaborative Membership Comparison



**Table 3. Comparative Percentage of Select Community Collaborative Participation Status**

FISCAL YEAR	Juvenile Justice	Education	Early Childhood	Substance Abuse	Parents
SFY 2002	46%	92%	58%	42%	79%
SFY 2001	42%	79%	54%	54%	38%
Change from SFY 01 to SFY 02	4%	13%	4%	-12%	41%

During SFY 2002, the number of existing Collaboratives, and those in development, increased from twenty-four (24) to twenty-seven (27). Most importantly, Community Collaborative coverage exists or is in development for every community in Connecticut. This is a tremendous change over last year where over 10 towns in the state did not have access to a Community Collaborative. Table 3 lists the Connecticut towns and cities that participate in a local Community Collaboratives.

All Connecticut's Community Collaboratives are expected to comply with mandates set forth in the Practice Standards for Community Collaboratives ("Practice Standards"). These Practice Standards provide guidance to the Community Collaboratives concerning the core values and key principles of the system of care approach, and direct the general structure that each Collaborative is to have. In keeping with the guiding principle of local community co-location of the systems of care, a myriad of native forces have shaped the development of each Community Collaborative. While each Collaborative has developed and typically operates in conformance with the Practice Standards, each Collaboratives uniqueness resonates through a creative spirit informed by the flavor and nuances of the communities that that they serve. This individualization is even supported through pre-service training for the Care Coordinators, which encourages each region to tailor segments of the curriculum, particularly that pertaining to culturally competency, to capture the specific identity of the communities to be served.

**Figure 6. Typical, "Mature" Collaborative Participation**

### Systems of Care Components

Connecticut's System of Care model has three, distinct structure levels that are identified in the Practice Standards:

**1. Child-Specific Teams (CST)**, sometimes called service review teams, include family members, the DCF social worker (where one has been assigned), a care manager, providers, and a family advocate. The team is responsible for individualized planning, the designation of a care manager, and the implementation of services. Consultation and assistance are available to the CST, as necessary from a local Ad Hoc Review Team (AHRT). The AHRT is a sub-group of the Community Resource Committee (see below)

**2. Community Resource Committees (CRC)** (formerly known as Case Review Committees) consists of broad community representation. The membership of the CRC is to be multidisciplinary and culturally diverse in order to

- Families of children with SED
- Consumers
- Clergy
- Family Advocates
- Insurance Companies
- Care Coordinators
- DCF Systems Coordinators
- DCF RRG Representatives
- Mental Health Clinicians
- Department of Social Services Representative
- Department of Mental Retardation Representative
- Juvenile Justice
- Legal
- Recreation

effectively meet the needs of children and families of the community to be served. (See Figure 4 for example of CRC membership).

The CRC is responsible for administrative/ financial support and assistance to child-specific teams, identification of service gaps in the local system, program planning and development and identification of potential new funding sources. It reports to an Interagency Management Team.

The macro-level planning in which the CRC engages is generally informed by monthly data updates provided by the Care Coordinators. The reports provided by the Care Coordinator to the CRC are limited to aggregations of the numbers of referrals received, numbers of open cases, numbers of cases closed since last CRC meeting, and number of DCF-involved/Non-DCF involved children on the caseload. Information on pervasive barriers to services and gaps in the service array may also be provided at the CRC meeting.

As noted above, child and family specific planning is to occur through well impaneled Child Special Teams. Advisement and technical assistance; however, may also be offered to families and their Care Coordinator by convening a CRC' Ad Hoc Review team meeting. As the name denotes, the Ad Hoc team is intended to be utilized sparingly, on occasions when there is a firm impasse or unyielding child specific issue. The Practice Standards require that a family's written consent is required to permit the convening of an Ad Hoc team.

**3. Interagency Management Teams (IMT)**, include membership of parents of children with SED, family advocate, at least one mental health clinician, and high-ranking agency administrators. A "best practice" is to include fund providing collaborative representatives on this level, as well as representatives from the Community Resource Committee. Examples are: Medicaid Managed Care Organizations or their Behavioral Health sub-contractors, the Department of Social Services, school systems, and other insurance companies, etc. The IMT functions to establish interagency agreements, identification of local needs and barriers, creation of new services, assess effectiveness of the CST's and CRC, and most importantly, serves as a steering committee for the local community concerning children's behavioral health services.

Memoranda of Agreement (MOA) among all participating parties on the CRC and IMT tiers of the System of Care has been identified as a component that aids in the collaborative process. While a number of collaboratives have not entered into formal agreements, tacit accords are in place and most teams continue to work collaboratively, productively and creatively to serve children with SED in their communities.

### **Child-Specific Teams and Case Review Committees**

Effective, well-run Child-Specific/Service Review Teams are ideally developed by the parents with advice from a Care Coordinator and a Family Advocate. A team is typically small, usually including clinical service provides, but should also have participation from members of the child's extended family, clergy, and informal helpers, as well as selected professionals. The essence of the CST is that the family being served determines those individuals and entities that invited to participate in the development of their child's Individual Service Plan (ISP).

### **Children's Behavioral Health Advisory Committee**

Section 2 of Public Act 00-188 establishes the Children's Behavioral Health Advisory Committee (CBHAC) to the State Advisory Council on Children and Families (SAC) to "promote and enhance the provision of behavioral health services for all children" in Connecticut (See Appendix 4). The CBHAC serves as the state's Children's Mental Health Planning Council as required by federal law, PL 321-102. The bylaws of CBHAC set forth that they will engage in the various duties outlined by PL 321-102 to ensure the advancement of the state's System of Care for children and families.

The 32-member CBHAC is comprised of the Commissioners of Children and Families, Social Services, Protection and Advocacy, Education, Mental Health and Addiction Services, Mental Retardation, or their respective designees; two Gubernatorial appointments, six members appointed by the leadership of the General Assembly, as well as sixteen members appointed by the chairperson of the SAC. The membership composition of the advisory committee is designed to equitably and adequately represent parents of children who have a serious emotional disturbance. "At least fifty per cent of the members of the advisory committee shall be persons who are parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child." In addition, a parent is to serve as co-chair of the CBHAC.

The bylaws governing the CBHAC outline their many responsibilities. In addition to the development of state's federal Children's Mental Health Plan, this committee reviews and approves all Practice Standards, including any amendments or modifications to those documents. During SFY 2001, the CBHAC approved an important change to the Practice Standards for the Systems of Care relating to the function and name of the middle tier of the Community Collaboratives. Prior to SFY 2001, the second tier of the Community Collaboratives was known as the Case Review Committee. This name, with its reference to Case Review, created tension and confusion as to the work of that committee. Many collaboratives reviewed child and family cases in front of a multiple person panel. Many of the panelists had limited or no service related involvement with the family. Therefore, the process was viewed to be intimidating and unpleasant for families who were typically asked to present before this large community empanelment.

Recognizing this blatantly "un-family friendly" practice, the work of the then Case Review Committee was revised to take-on a strong macro-community planning focus. The name of the Case Review Committee, with the approval of the CBHAC, was changed to the Community Resource Committee. During SFY 2002, the Community Collaboratives have worked assiduously to convert from a case review to a planning function. As this report will identify, most Collaboratives have done well in ensuring that child and family specific planning occurs only at the CST, and as appropriate, the Ad Hoc review team level.

A number of standing and ad hoc subcommittees are also established under CBHAC. Subcommittees related to the Community Collaboratives, include the Multiculturalism Subcommittee, The Grievance Committee, and the Care Coordination Quality Assurance Committee. These committees are responsible for developing recommendations and strategies to improve access and service through Connecticut's System of Care approach. In addition, the CBHAC serves as the Statewide Coordinated Care Committee (SCCC) in conformance with PA 97-272. Through the CBHAC's Grievance Committee, the duties of the SCCC are fulfilled. As present, the Grievance Committee is developing standardized documents and expounding upon the existing Community Collaborative grievance process to ensure broad awareness, and ease of understanding of the procedure for appeal.

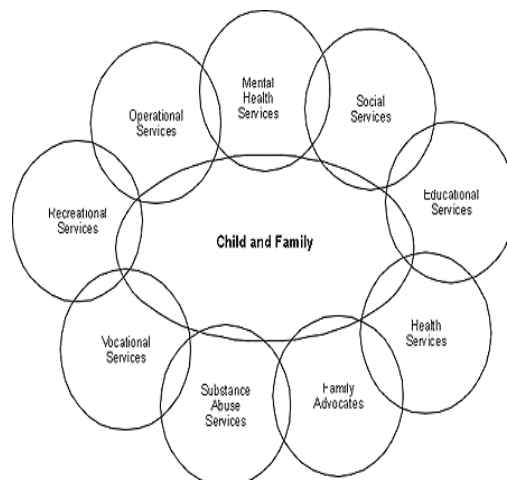


Figure 7. System of Care Dimensions

**Table 4. Select Participants in the Community Collaboratives**

Region	Collaborative	Parent	Juvenile Justice	Education	Early Childhood	Substance Abuse	Hospitals	Housing	Adult Mental Health	Insurance
SW	Greater Norwalk System of Care/CARE Team	NO	YES	NO	NO	NO	YES	NO	NO	NO
SW	Stamford System of Care Collaborative/CPR	YES	YES	YES	YES	YES	YES	YES	YES	
SW	Greater Bridgeport System of Care Collaborative	YES	YES	YES	YES	YES	YES	NO	NO	NO
SW	Stratford System of Care	NEW	NEW	NEW	NEW	NEW	NEW	NEW	NEW	NEW
SC	Lower Naugatuck Valley Collaborative	YES	NO	YES	YES	NO	NO	NO	YES	NO
SC	Family Access- Eastern Middlesex Collaborative	YES	YES	YES	NO	YES	YES	NO	NO	NO
SC	Valley Shore Collaborative	YES	YES	YES	YES	NO	YES	NO	NO	NO
SC	Middlesex System of Care	YES	YES	YES	YES	YES	YES	NO	NO	NO
SC	Shoreline Collaborative	YES	YES	YES	YES	YES	NO	NO	YES	YES
SC	Hamden/North Haven Collaborative	YES		YES	YES		NO	NO	YES	NO
SC	West Haven Collaborative	YES	YES	YES	YES	YES	NO	NO	YES	NO
SC	Bethany Orange Woodbridge Amity (BOWA) Collaborative	UNK	YES	YES	NO	NO	NO	NO	NO	NO
SC	Meriden/Wallingford Collaborative	NO	YES	YES	YES	NO	YES	NO	NO	NO
SC	Milford Collaborative	UNK	NO	YES	NO	NO	NO	NO	YES	NO
SC	New Haven Collaborative	YES	NO	YES	NO	NO	YES	NO	YES	NO
E	South Eastern Mental Health System of Care	YES	YES	YES	YES	NO	YES	NO	YES	YES
E	Communities Raising Children	YES	NO	YES		NO	YES	NO	YES	NO
NC	North Central System of Care	YES	NO	YES	YES	YES	YES	NO	YES	NO
NC	New Britain System Collaborative	YES	NO	YES	YES	NO	NO	NO	YES	NO
NC	Hartford/West Hart Collaborative	YES	NO	YES	NO	NO	YES	NO	YES	NO
NC	Greater Bristol Collaborative	NEW	NO	YES	YES	YES	YES	YES	YES	NO
NC	East of the River Collaborative	YES	NO	YES	YES	YES	YES	NO	YES	YES
NC	Newington, Rocky Hill and Wethersfield	NEW	NEW	NEW	NEW	NEW	NEW	NEW	NEW	NEW
NC	East Hartford Collaborative	NEW	NEW	NEW	NEW	NEW	NEW	NEW	NEW	NEW
NW	Waterbury Children's Action Council	YES	NO	YES	NO	YES	YES	NO	NO	NO
NW	Danbury System of Care Collaborative	YES	NO	YES	NO	NO	YES	NO	NO	NO
NW	NorthWest Corner System of Care	YES	NO	NO	NO	NO	NO	NO	NO	NO

Note: All Community Collaboratives also have representation from local mental health providers and social service agencies.

**KEY**

SW= SouthWest  
SC= SouthCentral

E= Eastern  
NC=NorthCentral

NW= NorthWest  
UNK= Unknown

Table 5. Existing and Developing Community Collaboratives by Region

Region	Collaborative	Towns
SW	Greater Norwalk System of Care/CARE Team	Norwalk, Westport, Weston, and Wilton
SW	Stamford System of Care Collaborative/CPR	Stamford, Greenwich, Darien, and New Canaan
SW	Greater Bridgeport System of Care Collaborative	Bridgeport, Trumbull, Fairfield, Monroe and Easton
SW	Stratford System of Care	Stratford
SC	Lower Naugatuck Valley Collaborative	Ansonia, Derby, Seymour and Shelton
SC	Family Access- Eastern Middlesex Collaborative	Portland, East Haddam and East Hampton
SC	Valley Shore Collaborative	Chester, Clinton, Deep River, Essex, Lyme, Old Lyme, Old Saybrook and Westbrook
SC	Middlesex System of Care	Middletown, Cromwell, Durham and Middlefield
SC	Shoreline Collaborative	East Haven, Branford, North Branford, Guilford, Madison, Clinton, Higganum and Killingworth
SC	Hamden/North Haven Collaborative	Hamden and North Haven
SC	West Haven Collaborative	West Haven
SC	Bethany Orange Woodbridge Amity (BOWA) Collaborative	Bethany, Orange, Woodbridge and Amity
SC	Meriden/Wallingford Collaborative	Meriden and Wallingford
SC	Milford Collaborative	Milford
SC	New Haven Collaborative	New Haven
E	South Eastern Mental Health System of Care	Bozrah, Colchester, East Lyme, Franklin, Griswold, Groton, Lebanon, Westbrook Ledyard, Lisbon, Lyme, Montville, New London, Stonington, N. Stonington Norwich, Preston, Salem, Sprague, Voluntown, Waterford
E	Communities Raising Children	Ashford, Brooklyn, Canterbury, Chaplin, East ford, Hampton, Killingly, Pomfret, Putnam, Scotland, Sterling, Thompson, Windham, Woodstock, Columbia Coventry, Union, Willington
NC	North Central System of Care	Enfield, Somers, Stafford Springs, East Windsor, Granby, East Granby, Suffield, Windsor Locks Bloomfield, Windsor
NC	New Britain System Collaborative	New Britain
NC	Hartford/West Hart Collaborative	Hartford and West Hartford
NC	Bristol Collaborative	Bristol
NC	East of the River Collaborative	Manchester, East Hartford, Glastonbury, Vernon, Tolland, Ellington, South Windsor, Hebron, Andover, Bolton, Marlborough
NW	Waterbury Children's Action Council	Beacon Falls, Bethlehem, Cheshire, Middlebury, Naugatuck, Oakville, Oxford, Prospect, Roxbury, Southbury, Waterbury Watertown, Washington, Wolcott, Woodbury
NC	Rocky Hill Newington Wethersfield Collaborative	Rocky Hill, Newington, Wethersfield, Kensington & Berlin
NW	Danbury System of Care Collaborative	Danbury, Redding, Ridgefield, New Milford, Bethel, Newtown, New Fairfield, Sherman, Bridgewater, Brookfield
NW	NorthWest Corner System of Care	Torrington, Salisbury, North Canaan, Norfolk, Colebrook, Hartland, Winchester, Oxford Barkhamstead, New Hartford, Goshen, Cornwall, Sharon, Kent, Warren, Litchfield, Morris, Harwinton Burlington, Thomaston

## CONNECTICUT COMMUNITY KIDCARE

In June of 1999, the Connecticut General Assembly requested that the Department of Social Services prepare a study of the financing and service delivery system for children's behavioral health. This study was in response to concerns about the bottlenecks and quality issues in children's mental health. A report to the legislature entitled, "Delivering and Financing Children's Behavioral Health Services in Connecticut," identified the five major needs of the service system:

1. Better mechanisms for coordination of care
2. Enhancing community-based resources and treatment alternatives
3. Integrated funding
4. Family involvement in policy as well as service planning for their own children
5. Redistribution of resources and refinancing of the service system

**Figure 8. Key KidCare Features**

Connecticut Community KidCare Key Features	
	<ul style="list-style-type: none"> <li>▪ Comprehensive health program with flexible benefit package including treatment and "wraparound" support services</li> <li>▪ Full carve-out HUSKY child behavioral health</li> <li>▪ Community-based and culturally competent care planning and service delivery</li> <li>▪ Greatly expanded community-based service capacity</li> <li>▪ Families involved and support in decision making role with strengthened family advocacy organizations</li> <li>▪ Comprehensive training for all agency and system staff and parents</li> <li>▪ Efficient balance of local control of care with statewide administrative support structure</li> <li>▪ Integrated funding to support broad benefit package</li> <li>▪ Reinvestment of increased Medicaid reimbursements</li> <li>▪ Routine performance reports on key outcomes and quality measures.</li> </ul>

Approximately a year later, in conformance with June Special Session Public Act 00-2, Section 5, the Department of Children and Families and the Department of Social Services (DSS) issued a report to the General Assembly entitled, *Connecticut Community KidCare: A Plan to Reform the Delivery and Financing of Children's Behavioral Health Services*. In this plan, DCF and DSS defined the vision for the "sweeping reform of the public child behavioral health service system."<sup>4</sup> The key features of KidCare were outlined.

KidCare is to build upon the partnerships with families, State agencies, and community providers that had been formed through the emerging System of Care Community Collaboratives. Through careful planning, training and capacity building, KidCare, using the nationally embraced System of Care model and wraparound philosophical approach, offers a blueprint for a cost effective, accountable, strength-based, family driven, culturally competent paradigm that gives families choice and help in caring for children with behavioral health challenges.

In the April 2002, DSS, DCF and DMHAS issued a legislative report entitled *Connecticut Behavioral Health Partnership: Developing an Integrated System of Financing and Delivering Public Behavioral Health Services for Children and Adults in Connecticut*. This report introduced Connecticut to a newly developed system of behavioral health services designed, administered and financed by the three (3) state departments aimed at developing a comprehensive approach to behavioral health care that encompasses the life span. The Health Care the key characteristics of the key KidCare reform are as follows:

- Expansion and enhancement of clinical and non-clinical support services,
- A primary focus on strengthening the family's capacity to help their child with behavioral health needs; and

<sup>4</sup> CT Community KidCare: A Plan to Reform the Delivery and Financing of the Children's Behavioral Health Services in Connecticut: Executive Summary

- A strong preference for delivery and management of service within the local community.

KidCare further defines the reform initiative by ushering greater service quality and accountability in the children's behavioral health system through performance and outcome measurements, centralized care management, integrated data management, and comprehensive training.

The federally defined System of Care Model underlies the paradigm shift in financing and service delivery in which KidCare is founded. Like the System of Care model, KidCare is based upon a philosophy in which service planning is driven by the needs and preferences of the child and family. Both KidCare and the systems of care model provided through the Community Collaboratives seek to prevent children's problems from escalating by offering an array of flexible, individualized services that will maintain children in their homes and community. KidCare and Connecticut's Community Collaboratives espouse quality, comprehensive, community-based service provision through partnerships, interagency agreements, and key-stakeholder associations. While KidCare is the materialization of systemic service restructuring, the systems of care approach has been the solid foundation created a decade ago in which to frame the core tenets of Connecticut's reform initiative.

### **INFRASTRUCTURE AND SYSTEM OF CARE APPROACH FIDELITY**

System infrastructure is the organizational and procedural framework for service delivery. KidCare recognizes the important role of assessment and evaluation in determining accountability, cost consciousness, and responsiveness; and whether the System of Care principles, such as family focus and cultural competence, and are evident in Community Collaboratives' infrastructure components (e.g., governance, management and operations, the array of services offered, and quality monitoring). DCF has contracted with the Child Health and Development Institute (CHDI) in Connecticut to assist in this important endeavor. CHDI has, in turn, subcontracted with Human Services Research Institute and the Technical Assistance Center from Massachusetts to independently evaluate the KidCare initiative. This evaluation will have multiple components: (1) an implementation analysis of system change activities; (2) an analysis of child and family outcomes; and (3) a cost-benefit analysis. A sub-study to assess Connecticut's families' satisfaction with the System of Care approach will occur during SFY 2003. This study will evaluate satisfaction with system responsiveness, perceived appropriateness of services, cultural competence of services, caregiver involvement in service decisions and outcomes of care.

The KidCare evaluation and the proposed sub-study will begin to fulfill the analytical void that has been articulated in previous Status Reports. Last year, the Status Reports author suggested that an evaluation of Connecticut's Community Collaboratives would need to assess the extent to which family members are actively involved in the administrative and planning tiers of the System of Care model. Quantitative and qualitative data related to the following critical questions were identified as a void that must be addressed: How many family members participated in System of Care policy and procedure development and in budgetary decisions? How many family members helped develop the service array or helped draft memoranda of agreement among participating agencies? Were the views of these family members respected and valued? Was their participation greater than, less than, or equal to that of other members?

Last year's report also suggested that in order to assure continuous quality improvement, the state must be able to evaluate service delivery. Gauging the activities and processes by which services are provided to children with complex behavioral health care needs and their families, including the point of entry into the system, service planning, service provision, and care monitoring and review; was identified as being important to evaluating service delivery efficacy. (See Figure 9).

The independent evaluation of KidCare will go a long way in helping to determining true family involvement and satisfaction with the Connecticut's children's behavioral health system. In addition, the role of the

emerging statewide family advocacy network will critically impact the mechanisms for determining the answers to the above questions and the flavor of those answers. The KidCare evaluation has been fastidious about meaningfully involving families at all stages of this endeavor (e.g., contractor selection, evaluation planning and data collection process). Families and Community Collaboratives will continue to need to be closely involved in ongoing evaluative processes, particularly at the back end in ensuring analytical integrity and broad, accessible data dissemination.

Figure 9: A Framework for Assessment of Infrastructure in SOC

### Fidelity:

Operationalization of the Core Values and Guiding Principles of the Community Collaboratives must occur. Figure 7 presents a conceptual framework that can aid the Collaboratives in assessing their level of fidelity with the integral elements of the system of care approach. At present, determining how and what occurrences represent concrete fidelity to the tenets of the system of care approach remains a challenge. The extent to which practices, activities and structures of the Collaboratives and attending services adhere to characteristics of the system of care and wraparound approach must be regularly assessed.

Element	Governance	Management & Operations	Service Array	Quality/Monitoring
Family Focused				
Culturally Competent				
Interagency				
Community Based				
Accessible				
Collaborative/ Coordinated				
Individualized				
Least Restrictive				

Many collaboratives have begun to concretize these principles through the empanelment of their tiers, the structure of their meetings, the types of subcommittees that they have developed and the protocols that they have embraced. Nevertheless, standardized tools, indicators and assessment methods will need to emerge in order to concretely measure fidelity.

### Linkages:

The Collaboratives' links with the community at large directly affect family involvement, cultural competence, and continuous quality improvement. In years past, many collaboratives would state that they represent the "community," yet there were unable to show through broad member representation that they actually did so. Changes over the past year suggests that most Collaboratives recognize the importance of broad community representation and have made concerted efforts to court and welcome new members, particularly families and non-traditional providers to the table.

Gaps continue to exist and all collaboratives will need to continue to recruit participation from schools, police, juvenile justice, clergy, recreation programs, housing, and the private sector. Outreach to all natural sources of support for families, including the faith community and fraternal or civic organizations, remains important in creating the supportive community environment that is needed to maintain children in their homes. In addition, the failure to secure broad representation of all parts of the community can effectively defeat the guiding principles and core values of the Systems of Care. Fortunately, during this past year, a number of Collaboratives have developed committees that are designated to initiate outreach for broader membership.

Strong linkages with the juvenile justice system need to be established by all Collaboratives. Care Coordination data indicate that 27 children served during SFY 2002 had criminal involvement; however, referrals to this service from juvenile justice personnel were rather modest (e.g., 6%). Studies suggests that that an "estimated 70-90 percent of youth suffers from mental illness, much higher than the estimated 10-20% for the non-delinquent juvenile population." (*The Prevalence of Mental Health Disabilities Among Youth*



in the Juvenile Justice System). Moreover, the overrepresentation of minorities in the juvenile justice system presents an importance reminder and challenge to ensure equitable access to mental health services for African American and Latino youth. Greater connections to faith-based organizations also need to occur. While increasing numbers of Collaboratives have made outreach to and have regular participation from clergy, there are still many teams that lack representation from this sector. National efforts to support faith-based initiatives may present an excellent opportunity for Collaboratives to forge linkage with houses of worship.

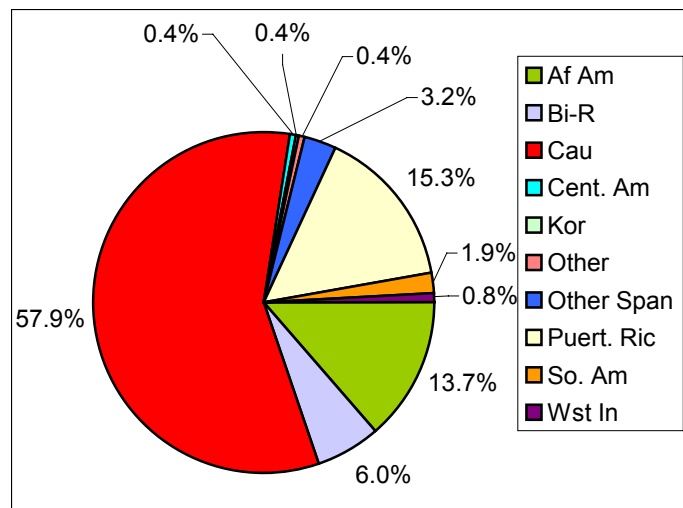
Another service center in which the Collaboratives continue to development linkages is with managed care organizations. The cost-efficient and ingenious approach taken by effective Community Collaboratives could be highly valued by managed care organizations, which want to contain the cost of behavioral health care and particularly by keeping children out of expensive, unnecessary inpatient or residential settings. Conversely, Community Collaboratives could use the resources of managed care to finance creative solutions to problems that would otherwise be prohibitively expensive to treat. Some collaboratives have begun to forge alliances with health insurance organizations and to work toward developing service access agreements. When a Community Collaborative deems an eligible family appropriate for a behavioral health intervention, for example, the family may be guaranteed a specified number of in-home visits without prior authorization by the insurance company.

## CULTURAL COMPETENCE

Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that allow all parties to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989; Isaacs & Benjamin, 1991). In keeping with national System of Care promising practices, each System of Care must value diversity, be capable of cultural self-assessment, grasp the dynamics inherent in cultural interaction, have institutionalized cultural knowledge, and know how to adapt service delivery to accommodate cultural difference.

In Connecticut, cultural competence is an area that continues to pose a challenge for all Community Collaboratives. This is not to suggest that the Collaboratives are insensitive to this issue. To the contrary, many Collaboratives have identified issues pertaining to cultural competency from the attempts and overtures they have made to attain a responsive level of service. The specific cultural competency issues that each Collaborative faces varies between communities (e.g., outreach, membership, transportation, staff, translation services, programming, etc.), but all Collaboratives appear to be cognizant of the importance of cultural competence in effective planning, service development and care management. Many collaboratives have engaged in activities that evidence their awareness of this issue. For example, some Collaboratives have created material in Spanish and are actively seeking to have documents translated into other community relevant languages (e.g., Polish in the New Britain area). Others have identified

**Figure 10. Care Coordination by Ethnicity**



Af Am= African American	Cent Am= Central American
Bi-R= Bi-Racial	Kor=Korean
Cau= Caucasian	Other Span= Other Spanish Speaking
Puert. Ric= Puerto Rican	So.Am= South American
Wst In= West Indies/Islanders	

resources and supports to assist families who are grappling with issues of poverty that impede positive outcomes for their child.

The emphasis on the provision of culturally competent services and outcome parity under KidCare will likely further assist the Collaboratives in this endeavor by making additional resources and technical assistance available. This is most evident through the change in staff diversity for the Care Coordination programs. Funding under KidCare has allowed many Collaboratives to hire multicultural and/or bi-lingual Care Coordinators. Increased funding and a clear emphasis on the provision of culturally responsive service through the procurement process, has yielded a significant increase in the number of males, African Americans, Latinos and Spanish-speaking persons employed as Care Coordinators for the Community Collaboratives. In addition, culturally diverse Family Advocates have been hired over the past couple of years. It is likely that these improvements will facilitate greater access and even better care outcomes for culturally and linguistically diverse children and their families.

In fact, there seems to be no evidence of exclusionary practices; all systems express interest in serving all cultural and ethnic groups in their area and extending Community Collaborative membership to diverse populations. Data from monthly Care Coordination reporting indicates that during SFY 2001 – 2002, the System of Care caseload was 58% Caucasians (slightly lower than the state's population statistics), 14.5% African American, 15% Hispanic and 6% Bi/Multiracial.

While these important achievements must not go unrecognized, Collaboratives must not become complacent or fail to develop plans to increase effective service provision that is specific to other statuses (e.g., gender, age, sexual orientation, poverty, religion, etc.). Moreover, while the provision of Care Coordination to the state's ethnic minorities is slightly over current census percentages, it is not clear if service levels are consonant with actual need. Furthermore, predictions for increases in Connecticut's African American and Latino population suggest that entities such as Community Collaboratives must develop evolving culturally responsive strategies to keep pace with needs. This is particularly important, as few collaboratives have engaged in other prominent, enduring activities to support the provision of culturally competent care. This limited engagement of cultural competence, seems to be attributable to confusion about operationalizing this complex, and multi-faceted issue.

Many Collaboratives know that equitable service outcomes are associated with cultural competence, yet few seem to fully grasp this subject and often categorize it as a race, ethnicity and language oriented matter. The need for the Collaboratives to pervasively embrace a definition of culture that is broader in focus (e.g., poverty, physical disability sexual orientation, gender, etc.) may aid in solidifying the focus and framing the necessary initiatives to achieve cultural competence. Continued training and additional resources will be important contributors to operationalizing a strategy for culturally responsive care.

Federal funding from the Mental Health Block Grant have been earmarked for this purpose. Each DCF region will be given funding to work with the Collaboratives to create a community endorsed workplan for achieving improvement in culturally competent service provision. During FFY 2003, the Community Collaboratives will be provided with opportunities to share in the best practices that emerge through this targeted funding initiative.

Nationally, there is growing demand for greater cultural competence in the Systems of Care approach. Current literature identifies a confluence of factors that affect mental health service utilization rates (Sue & Sue, 1990). The cumulative impact of these factors is typically negative, with lower utilization rates for some services reported among non-Caucasian families (SAMSHA, 1999). Culturally diverse service providers are often absent from the Systems of Care table. The absence of broad community representation within the Systems of Care may contribute to underutilization and clearly undermines the development of cultural competence. As analysis of the KidCare initiative occurs a more in-depth review of whether Community

Collaborative use by non-Caucasian families is disproportionately low based upon need must occur; particularly, this evaluation will need to review the interrelationship between behavioral needs of juvenile justice and their access to and referrals to the System of Care Community Collaboratives.

Similar to most states, Connecticut must continue to move forward with its efforts to develop culturally competent Systems of Care and a culturally responsive service array. Data suggest that when services are linked to a community's culture, higher rates of utilization, lower attrition, and improved outcomes can be expected (Sue & Sue, 1990). *The Evaluation of the Comprehensive Mental Health Services for Children and Their Families Program- Annual Report to Congress: 1999* identifies strategies to support cultural competence:

- Taskforce to address cultural competence
- Targeted outreach
- Conducting assessments of community needs related to cultural issues
- Formal cultural assessment of client populations
- Considering cultural issues in developing service array
- Creative approaches
- Training

As the above strategies identify, there is a need for multiple, ongoing dynamic approaches. Only some of these strategies have been incorporated into the structure of most Collaboratives. Mechanisms and resources to support the full integration of cultural competence into the domains of the Community Collaboratives must occur. A basic step might be the operationalization of cultural competence, through the development of indicators to guide cultural competent practice. In addition, the CBHAC Multiculturalism Subcommittee must take a leadership role in identifying best practices and offering technical assistance to the Collaboratives so that they can more comfortably embrace this issue.

## **PRACTICE STANDARDS**

A group representing parents of children with SED, Care Coordinators, schools, juvenile courts, child guidance clinics, and other key stakeholders spent nineteen months developing practice standards for Connecticut's Systems of Care. The statewide Coordinating Council and the DCF Commissioner approved these standards in January 2000. The standards, which identify best practices for specific operational aspects of Systems of Care (membership, intake and assessment, criteria for closing cases, child and family rights, etc.), drew on information provided by exemplary programs throughout the country and identified the need for "one or more standardized outcome measures at all Systems of Care in the state." In furtherance of DCF's commitment to providing efficacious System of Care services, collaboratives must agree to follow the Practice Standards in order to receive funds to support Care Coordination services.

As note earlier, revisions to the Practice Standards have occurred. A subcommittee was impaneled to draft language that provided guidance on the middle tier of the Systems of Care. In the past, there was great variance in how the than Case Review Committee functioned. Over the course of a number of months, a group consisting of Care Coordinators, Family Advocates, Systems Coordinators and DCF Mental Health Division Staff crafted language that more explicitly defined the roles and duties of the now term Community Resource Committee (CRC).

Collaboratives; however, are most conspicuously out of compliance with the Practice Standards in the areas of family involvement, documentation, and affirmation of families' rights. As noted above, it has been difficult to involve parents at all levels of the System of Care. Some collaboratives have worked diligently to ensure regular participation by at least one or two parents on the Community Resource Committees. Others have been only marginally successful in this regard. Nevertheless, the majority of Collaboratives have made progress over the past years in terms of their success in securing regular, meaningful parent participation at planning levels; and engaging in strategies to generally improve family involvement and final

outcomes. The emergence of a statewide family advocacy effort has certainly contributed to this improvement, but continued diligence is needed to ensure that all Collaboratives have membership by families at the CRC and IMT levels. Documentation is an important component of efficient service delivery within the System of Care model. The Practice Standards specify certain forms of documentation and set forth protocols for its use; the various forms include a Uniform Client Record, policies and procedures, documents granting consent, confidentiality statements, lists of collaborative members, consumer satisfaction surveys, and so forth. In the past, the documents between Community Collaboratives were very different. While all collaboratives had some type of referral form, the information collected on that document was inconsistent. Through the development of a Uniform Client Record, a standard referral form is to be used by all collaboratives. This form is to be completed before the referral is reviewed for eligibility. This seemingly simple requirement is one of the very important checks and balances designed to ensure that families' rights are safeguarded.

The Quality Assurance Committee for Care Coordination has taken the lead in developing standardized material for the Community Collaboratives. During SFY 2002, this committee has created uniform Care Coordination discharge criteria, consent forms for the CST and Ad Hoc Review Teams, and release of information forms. These new, standardized forms will assist all Collaboratives in their baseline compliance with the Practice Standards, but will more importantly better ensure the integrity of the Care Coordination service and the system of care approach throughout the state.

### **UNIFORM CLIENT RECORD and ASSESSMENT TOOLS**

In March of 2001, the Children's Behavioral Health Advisory Committee unanimously ratified the contents and use of a Uniform Client Record for the Systems of Care (UCR) and the use of two assessment tools as an amendment to the Practice Standards. An "Assessment Advisory Committee," which included direct input from Care Coordinators, Family Advocates, family members, staff of DCF and other state agencies (SDE and OPM), providers, university faculty members, and consultants, developed the UCR and selected the assessment tools over the course of a year. In addition, all Care Coordinators in the system in the 2000-2001 period had opportunities to provide input, and eight care coordinators "piloted" the UCR in the spring of 2001.

The UCR was intended to and has raised the level of professional Care Coordination practice, standardized Care Coordination across Connecticut, and make the receipt of services easier for families who move within the State and continue to require services. In particular, the UCR outlines the protocols that measure and assess client's strengths, needs, and challenges, identify functional improvement during the course of service, and identify the aspects of interventions that prove most effective with clients matching various profiles of needs, challenges, and strengths. (See Appendix 5). During SFY 2002, the UCR was translated into Spanish and a finalized version of the Spanish UCR is in development.

Concomitant with the creation of the UCR, was the decision to use two scales to assess children and families receiving Care Coordination through the Community Collaboratives. The instruments, *Ohio Youth Problem, Functioning and Satisfaction Scales (Ohio Scales)* and the *Behavioral and Emotional Rating Scale (BERS)*, were selected because they were viewed to be comprehensive, strengths-based assessments, consistent with all the best practices endorsed in system of care literature. Recognizing the need for culturally competent assessments, the BERS and Ohio Scales were also chosen due to their availability in Spanish.

Training pertaining to the UCR and the attending assessment tools has been a priority during SFY 2001 & 2002. Laurel Robertson, PhD, who has extensive experience with the successful Santa Barbara, California System of Care initiative, instructed the Care Coordinators on the proper use and scoring of the assessment tools. Refresher-training sessions were held in August 2001 and a 4-day Care Coordination Pre-Service

Training Curriculum was created this past spring, with more senior Care Coordinators and Family Advocates becoming trainers.

The Care Coordination Pre-Service Curriculum ensures that all new Care Coordinators are conversant in the values and principles of the system of care model, taught how to properly complete the UCR, and expertly administer and score the BERS and Ohio Scales. This Pre-Service training is intended to dovetail with the KidCare Institute Training that has been unfurled statewide. All Care Coordinators are required to complete this pre-service training as a condition of their employment. The Pre-Service Training occurs at the local level to ensure that community specific information is woven throughout the curriculum.

## **REGIONAL SYSTEMS COORDINATORS**

DCF has designated System of Care Coordinators (Systems Coordinators) in each of the five regions. The System Coordinator is an employee of the Department of Children and Families who is available to the community and DCF staff to provide training and information on local collaboratives and the statewide System of Care initiative. These individuals are responsible for community organization and for helping develop local Community Collaboratives. In this capacity, the Systems Coordinators provide technical assistance to the various tiers within the System of Care model on clarification of and compliance with the Practice Standards. In addition, the Department maintains a statewide System of Care Program Supervisor. This position provides consultation and support to the regional Community Collaborative development efforts.

During the authoring of the 2001 Status Report, a Systems Coordinator had not been identified in one region for nearly two years. This has since been rectified, with all regions employing a full-time Systems Coordinator. Also, in years past, the majority of the Systems Coordinators had upwards of 60% of their time directed towards activities that were marginally related to their intended Community Collaborative duties. This has changed significantly. Presently, most Systems Coordinators engage in limited contract management responsibilities and other non-KidCare related activities. Only a couple of regions still utilize the Systems Coordinators in a manner that deflects their time and attention from organizing and consulting from local Collaboratives.

## **CARE COORDINATION**

Care Coordination, once called "Case Management," is an essential part of the system of care approach. Like Family Advocacy, Care Coordination is an integral component of effective service delivery within the System of Care model. A lack of services in this area compromises the ability of collaboratives to achieve identified goals; thus underscoring the importance of having a full-time Care Coordinator available to all existing and developing Systems of Care collaboratives. The funding under KidCare, which has more than doubled the number of Care Coordinators, has allowed for all towns in the state to have access to a Community Collaborative and enable those Collaboratives without a Care Coordinator to increase the number of families served and the effectiveness of their involvement.

Care Coordinators serve a very important quarterbacking role in aiding families in obtaining and organizing the complement of services and supports needed to maintain children in their communities. Coordinators must be creative, resourceful, empathetic, trustful, and diplomatic. The challenge is adeptly controlling the flow of information between integral players to ensure families receive seamless, non-duplicative and counter indicated services.

Care Coordination is both a service to children and families and a sign that the system is responsive. As a service, Care Coordination is carried out in Connecticut on three levels that are explained below. The term "Care Coordinator" is associated with Level III Care Coordination, or intensive Care Coordination reserved for children and youth with the greatest need. At this level there is extensive work with each family to assess the situation and to develop and implement a service plan.

As a service, then, Care Coordination involves direct client contact by someone who has clinical knowledge but who does not act as the clinician on the case. Rather, the Care Coordinator, who develops the service plan along with the family, uses clinical knowledge and awareness of community systems to broker and advocate for services and to synchronize the child and families Individual Service Plan (ISP).

The three levels of Care Coordination reflect varying levels of need on the part of the child and the family.

- *Level I:* When a child is involved in only one service component, the child's service provider or a member of the multidisciplinary team assigned to the child is responsible for care management in partnership with the family.
- *Level II:* When a child has a DCF worker, the child's worker serves as the care coordinator collaborating with the child's primary service provider or with a member of the assigned multidisciplinary team.
- *Level III:* When a child is involved with several agencies and is identified as needing care management independent of any particular service received, care management is performed by the DCF caseworker in conjunction with a full-time care coordinator provided through the System of Care (when funds permit). Such care coordinators have a small caseload—typically eight to twelve active cases at any given time and thirty-six in the course of a year.

As the hallmark of a responsive system, "Care Coordination" is more broadly defined. It means that the System of Care operates in such a way that services are individualized, take into account family preferences, are flexible in format, use professional and natural supports, have a tracking component to ensure implementation, and can be monitored. Care Coordination in a responsive system also promotes partnership with other institutions such school systems, juvenile courts, and social agencies and links organizations that are or might be directly involved in the collaborative. This facilitating function may be carried out by the employed Care Coordinator or by various other members of the System of Care.

It must be noted that Care Coordination and the Emergency Mobile Services (EMS) program have been linked contractual. This new relationship has added a direct clinical element to the Care Coordination service and facilitates an improved treatment continuity and service fluidity for children who experience a psychiatric crisis and require a connection to their local Community Collaborative. Further impact of formally connecting these services will need to be monitored over the next several months. For example, past data indicated that the emergency mobile service programs only marginally referred children to the Community Collaboratives. The new relation can only increase the number of children who are referred for Care Coordination and may change the demographics and acuity of the youngsters who present to the Collaboratives. Scrupulous review of the Care Coordination data and its interlace with EMS data; and monitoring of provider and consumer feedback, will be important to this process.

### **Caseload Characteristics**

Data collection has been a priority for the Department for the past several years. The Division of Mental Health has been working with providers and families to create comprehensive data collection tools to inform ongoing planning and service development. Care Coordination data for the period of July 1, 2001 –July 1, 2002 reveals the following:

- 432 children received care coordination services at some time in the twelve-month period of 7/1/01 – 6/30/02. With the enhancement of care coordination as one of the initial KidCare services from 16 coordinators to 60, the capacity will be to serve about 1200 children per year.

- The average age is 11.98<sup>5</sup> years and 70% are boys, which is consistent with nationwide samples of children served in systems of care. In terms of ethnicity, 58% are Caucasian/White, 14.5% are Black (African-American and West Indies Islanders), and 15% are Puerto-Rican, and 6% are Bi-Racial. This means that minority youth are served in higher proportion to the state's census figures.
- The great majority of children (76.5%) live with one or both biological parents.
- 69% of the children served in care coordination are in Special education and there were an average of eight days absent from school in the past 60 days of scheduled classes.
- Twenty-seven of the 252 youth were arrested in the six months prior to enrollment in care coordination.
- The most frequent referral sources are DCF (21.7%), parents (18%), and child guidance clinics (12.3%) and schools (10.7%). Only 37.5% of the children served have no current or prior involvement with DCF. Referrals for children in Voluntary Services accounted for 18.5% of all referrals, while referrals of children in Protective Services and Committed (abuse, neglect, uncared for) comprised 15.3% and 8.5%, respectively.
- Sixty-nine percent (69%) of the children receiving care coordination services are enrolled in special education. This includes a small number enrolled in "Section 504" education services.
- Unfortunately, the demand for care coordination far exceeded the supply in 2001-2002. Survey respondents suggest that upwards of 610 referrals for the Systems of Care were received during SFY 2002. In addition, data indicates that there was a statewide average wait of 32 days for enrollment into care coordination services. The wait was longest in the South West region (92.55 days) and shortest in the South Central region (8.13 days).
- In terms of risk factors in the family environment, 42.3% of children have had mental illness in their family, 30% live in poverty, 22.2% have had substance or alcohol abuse and domestic violence was present in 21.8%.

**TABLE 6. Client Family Type**

<b>Family Type: n (%)</b>	<b>SW n=32</b>	<b>SC n=91</b>	<b>E n=29</b>	<b>NC n=55</b>	<b>NW n=36</b>
Adoptive family	0 (0%)	4 (4.4%)	5 (17.2%)	2 (3.6%)	5 (13.9%)
Biological family	32 (100%)	72 (79.1%)	15 (51.7%)	44 (80.0%)	23 (63.9%)
Emancipated	0 (0%)	1 (1.1%)	0 (0%)	0 (0%)	0 (0%)
Foster family	0 (0%)	3 (3.3%)	4 (13.8%)	1 (1.8%)	3 (8.3%)
Relative/Guardian Care	0 (0%)	11 (12.1%)	4 (13.8%)	7 (12.7%)	3 (8.3%)
Not one of the above	0 (0%)	0 (0%)	1 (3.4%)	1 (1.8%)	1 (2.8%)

<sup>5</sup> Age is based on prior analysis. This will be updated shortly.

TABLE 7. Referral Source

REGION	SW	SC	E	NC	NW	TOTAL
Referral Source: n (%)	n=31	n=91	n=29	n=54	n=39	N=244
DCF	9 (29.0%)	9 (9.9%)	12 (41.4%)	14 (25.9%)	9 (23.1%)	53 (21.7%)
Bridgeport DCF	7 (22.6%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	7 (2.9%)
Danbury DCF	0 (0%)	1 (1.1%)	0 (0%)	0 (0%)	3 (7.7%)	4 (1.6%)
Hartford DCF	0 (0%)	0 (0%)	0 (0%)	11 (20.4%)	0 (0%)	11 (4.5%)
Manchester DCF	0 (0%)	0 (0%)	0 (0%)	2 (3.7%)	0 (0%)	2 (.8%)
Meriden DCF	0 (0%)	2 (2.2%)	0 (0%)	0 (0%)	0 (0%)	2 (.8%)
New Haven DCF	0 (0%)	6 (6.6%)	0 (0%)	0 (0%)	0 (0%)	6 (2.5%)
Norwich DCF	0 (0%)	0 (0%)	5 (17.2%)	0 (0%)	0 (0%)	5 (2.0%)
Stamford DCF	1 (3.2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (.4%)
Torrington DCF	0 (0%)	0 (0%)	0 (0%)	1 (1.9%)	4 (10.3%)	5 (2.0%)
Waterbury DCF	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (5.1%)	2 (.8%)
Willimantic DCF	0 (0%)	0 (0%)	6 (20.7%)	0 (0%)	0 (0%)	6 (2.5%)
DCF Unspecified	1 (3.2%)	0 (0%)	1 (3.4%)	0 (0%)	0 (0%)	2 (.8%)
Child Guidance Clinic	7 (22.6%)	17 (18.7%)	1 (3.4%)	3 (5.6%)	2 (5.1%)	30 (5.1%)
Department of Social Services	0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (5.1%)	2 (.8%)
Emergency Psych Treatment	0 (0%)	3 (3.3%)	0 (0%)	0 (0%)	0 (0%)	3 (1.2%)
Extended Day Treatment	0 (0%)	4 (4.4%)	1 (3.4%)	0 (0%)	0 (0%)	5 (2.0%)
Family Advocate	0 (0%)	1 (1.1%)	0 (0%)	1 (1.9%)	0 (0%)	2 (.8%)
Foster Family	0 (0%)	0 (0%)	2 (6.9%)	0 (0%)	0 (0%)	2 (.8%)
Friend	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1.9%)	1 (.4%)
Group Home	0 (0%)	0 (0%)	1 (3.4%)	0 (0%)	0 (0%)	1 (.4%)
Hospital	1 (3.2%)	3 (3.3%)	2 (6.9%)	3 (5.6%)	0 (0%)	9 (3.7%)
Intensive Family Preservation	2 (6.5%)	3 (3.3%)	0 (0%)	1 (1.9%)	2 (6.5%)	6 (2.5%)
Juvenile court, probation, or parole	1 (3.2%)	1 (1.1%)	0 (0%)	1 (1.9%)	0 (0%)	3 (1.2%)
Other	0 (0%)	8 (8.8%)	0 (0%)	4 (7.4%)	0 (0%)	12 (4.9%)
Parent	5 (16.1%)	13 (14.3%)	3 (10.3%)	4 (7.4%)	19 (48.7%)	44 (18.0%)
Parent aide	0 (0%)	0 (0%)	1 (3.4%)	1 (1.9%)	0 (0%)	2 (.8%)



TABLE 7. Referral Source -Continued

REGION	SW	SC	E	NC	NW	TOTAL
Referral Source: n (%)	n=31	n=91	n=29	n=54	n=39	N=244
Partial hospitalization	0 (0%)	3 (3.3%)	3 (10.3%)	1 (1.9%)	2 (5.1%)	9 (3.7%)
Physician	0 (0%)	1 (1.1%)	0 (0%)	0 (0%)	0 (0%)	1 (.4%)
Private provider	2 (6.5%)	1 (1.1%)	0 (0%)	2 (3.7%)	0 (0%)	5 (2.0%)
Relative or friend	0 (0%)	1 (1.1%)	0 (0%)	1 (1.9%)	2 (5.1%)	4 (1.6%)
Residential facility	0 (0%)	2 (2.2%)	0 (0%)	0 (0%)	0 (0%)	2 (.8%)
School	3 (9.7%)	15 (16.5%)	1 (3.4%)	4 (7.4%)	3 (7.7%)	26 (10.7%)
Self	1 (3.2%)	6 (6.6%)	1 (3.4%)	4 (7.4%)	0 (0%)	12 (4.9%)
Social service agency	0 (0%)	0 (0%)	1 (3.4%)	0 (0%)	0 (0%)	1 (.4%)
Youth service bureau	0 (0%)	3 (3.3%)	0 (0%)	0 (0%)	1 (2.6%)	4 (1.6%)

The major referral sources to the Community Collaboratives for 2002 remain similar to those of last year. DCF's regional offices, schools, parents and the Child Guidance Clinics continued to initiate referral to the Community Collaboratives. Conversely, referrals from the juvenile justice system, hospitals, residential treatment facilities and emergency mobile psychiatric services (EMS) were limited in both 2001 and 2002. Programming enhancements under KidCare, such as the linkage of the EMS and Care Coordination contracts, and a greater nexus between behavioral health services and the juvenile justice system, will likely impact the referral sources.

This caseload characteristics information seems to support key trends and priorities that have emerged under KidCare. For example, Family Involvement, Cultural Competency, serving Juvenile Justice populations, and cultivating partnerships with the Educational System are areas that are prominent on the KidCare agenda. As the Care Coordination data indicates, 69% of the children receiving this service are Special Education involved, and that 55% of the cases identify problems in school as the rationale for the referral. Clearly, this underscores the importance of partnering with schools to create effective programming for the children receiving services through the Community Collaboratives.

In addition, the importance of family empowerment is evidenced by the fact that "families/self" are the number one referral source for Care Coordination. Enhancing families' knowledge base and system competency will increasingly aid caregivers in identify necessary services and supports to maintain their children in their homes and communities. Finally, as 48% of the referrals for Care Coordination identifying physical violence/aggression and conduct disorders as presenting issues, this information would seem to suggest an importance of developing strategies to ensure that youth who are exhibiting externalizing behaviors that may have been criminalized have linkages to the Community Collaboratives. While the statistical data for this information identifies externalizing behaviors have a major presenting issue, few referrals actual emanate from the juvenile justice system.

#### PARENTAL INVOLVEMENT & FAMILY ADVOCACY

The emerging family movement in the past ten years has given a strong voice to families raising children with mental health needs, emotional disorders, and behavioral problems. According to *Mental Health: A Report of the Surgeon General*, "The role of families has been redefined as that of a partner in care"

(SAMSHA, 1999, p. 193). The results from the federal children's mental health initiative, which funded over forty demonstration System of Care projects, reveal that the most successful systems are those in which family members of disturbed children are treated as equal partners collaborating with administrators and providers (Osher, DeFur, Spencer, & Tosh-Denis, 1999). In describing their Family Network and Support Program, CMHS notes that "Over the past 15 years, increasing evidence . . . suggest[s] the engagement of trained and empowered family members is an essential ingredient of systems of care, and that such systems can result in increased family satisfaction for themselves as a family unit and for their children in specific."

Facilitating meaningful family involvement through the Systems of Care approach stands as a prominent concern in Connecticut, as well as nationally. The state's Community Collaboratives have progressively adopted strategies to welcome and sustain caregiver involvement on all levels of the consortium. During FFY 2002, there is clear evidence that all Collaboratives are focused on establishing practices that will attract families to the System of Care approach. This is a tremendous gain over previous years in which

**Table 8. Parent Members on Community Collaboratives**

Region	Collaborative	Average # Parents
SW	Greater Norwalk System of Care/CARE Team	0
SW	Stamford System of Care Collaborative/CPR	1
SW	Greater Bridgeport System of Care Collaborative	3
SW	Stratford System of Care	NEW
SC	Lower Naugatuck Valley Collaborative	2
SC	Family Access- Eastern Middlesex Collaborative	3
SC	Valley Shore Collaborative	3
SC	Middlesex System of Care	4
SC	Shoreline Collaborative	1
SC	Hamden/North Haven Collaborative	2
SC	West Haven Collaborative	1
SC	Bethany Orange Woodbridge Amity (BOWA) Collaborative	UNK
SC	Meriden/Wallingford Collaborative	0
SC	Milford Collaborative	UNK
SC	New Haven Collaborative	1
E	South Eastern Mental Health System of Care	5
E	Communities Raising Children	3
NC	North Central System of Care	2
NC	New Britain System Collaborative	3
NC	Hartford/West Hart Collaborative	9
NC	Bristol Collaborative	NEW
NC	East of the River Collaborative	2
NW	Waterbury Children's Action Council	9
NW	Danbury System of Care Collaborative	2
NW	NorthWest Corner System of Care	5
<b>TOTAL-AVERAGE</b>		<b>3</b>

some Collaborative were struggling with the inclusion of families /or insensitive to the needs and value contributions of families at the community planning levels of the system of care model. The number of Collaboratives that have families on their CRC's and the number of caregivers reported as being members of the Community Collaboratives has increased since last year. The 2001 Status Report Survey revealed that nine (9) Collaboratives did not have families as members, compared to only approximately three (3) Collaboratives in 2002.

Information for SFY 2002 indicates that most Collaboratives have changed their perspective on this issue and have made solid progress in expanding their membership to include parents. Collaboratives have worked to create a welcoming climate for parents of children with SED. As noted, 79% of the reporting Collaboratives indicate that they have parent members on the CRC and/or IMT levels. In general, it appears that parents who sit on the Collaboratives are valued and respected by other members of the teams. Critical factors that must be recognized as aiding this positive change include: changes to the Practice Standards that clarified the role of the CRC, DCF's securing funding to provide families with stipend to compensate them for their participation on KidCare workgroup, creation of FAVOR, and the going-on diligence of the Family Advocates.

Nevertheless, obstacles to meaningful involvement of Connecticut's families still exist. Barriers include lack of child care, lack of transportation, inability to secure time off from work to attend regular meetings, and the inability of Systems of Care collaboratives to offer parents nominal stipends that compensate them for expenses incurred. Nonetheless, a few systems have modified their meeting time to court participation (e.g., evening) and have held special meetings at family-friendly times on a quarterly or semiannual basis. Some Collaboratives have developed Parent Advisory Group as a further measure to garner meaningful family involvement. In addition, a number of Collaboratives have applied for funding, particularly from the Connecticut Health Foundation, to develop initiatives that will increase opportunities for families to participate on the various levels of the service system.

Possible roles for families include advocacy at the individual and the community level, extending the reach of the funded family advocacy program; policy making and advocacy at the system level on the case review committee and/or the interagency management team; leadership of support groups; provision of selected services (e.g., respite); leadership as System of Care facilitators or care coordinators; participation in evaluation, assessment, program monitoring, and outcome measurement. Families could also help educate service providers; families in Vermont, Indiana, and California teach graduate students in professional programs about raising children with serious emotional disturbances (Osher et al., 1999).

### **Parent Surveys**

A new addition to the System of Care Status Report is the development of a Family Survey. In collaboration with a CBHAC member and Family Advocate, the DCF Mental Health Division created a six (6)-question survey that was targeted to caregivers who had received Care Coordination through the Community Collaboratives during SFY 2002. This instrument, adapted from a survey from the Research and Training Center on Family Support and Children's Mental Health from Portland State University, assessed families' perspective of Community Collaborative's fidelity with core elements of the System of Care approach. Using a likert-scale with values from 1 through 5 (5 being the highest rating), the following three questions were presented on the survey:

1. *Please rate the extent to which your ideas were valued in the System of Care's service planning process(es) for your child and family*
2. *Please rate the extent to which your family's values and culture were taken into account when planning for your child*
3. *How would you rate your overall experience with the Systems of Care Community Collaboratives*

In order to encourage completion of the surveys, families were provided with a pre-stamped envelope, addressed to a Community Collaborative family advocate. Twenty-nine (29) Family Surveys were received, representing fourteen (14) Collaboratives. The surveys revealed that responding families were generally pleased with their role within the system of care approach and rated their overall experience as "Very Good" to "Excellent". The following table illustrates families' ratings for the three likert-scale questions:

**Table 9. Responses to Questions 1-3 on the Parent Survey**

Collaborative	Question1	Question2	Question3
Greater Norwalk System of Care/CARE Team	5	5	5
Greater Norwalk System of Care/CARE Team	5	5	4
Greater Norwalk System of Care/CARE Team	5	5	5
Greater Norwalk System of Care/CARE Team	5	5	5
Greater Norwalk System of Care/CARE Team	4	4	4
Stamford System of Care Collaborative/CPR	5	5	5
Stamford System of Care Collaborative/CPR	5	5	5
Stamford System of Care Collaborative/CPR	5	5	5
Middlesex System of Care	5	5	5
Middlesex System of Care	4	3	5
New Haven Collaborative	5	5	5
New Haven Collaborative	5	5	4
New Haven Collaborative	5	4	4
Hamden/North Haven Collaborative	5	5	5
Hamden/North Haven Collaborative	5	5	5
West Haven Collaborative	4	4	5
Bethany Orange Woodbridge Amity (BOWA) Collaborative	5	4	4
Milford Collaborative	4	4	5
Milford Collaborative	5	5	5
North Central System of Care	4	4	3
Hartford/West Hart Collaborative	5	4	4
Hartford/West Hart Collaborative	4	4	4
North Central System of Care	4	4	3
Hartford/West Hart Collaborative	5	4	4
Hartford/West Hart Collaborative	4	4	4
East of the River Collaborative	5	5	5
East of the River Collaborative	5	5	5
Waterbury Children's Action Council	5	5	4
Danbury System of Care Collaborative	5	4	5
Danbury System of Care Collaborative	5	5	5
NorthWest Corner System of Care	5	5	5
NorthWest Corner System of Care	5	5	5
<b>Average</b>	<b>4.8</b>	<b>4.6</b>	<b>4.7</b>

1=Not at all/  
Poor  
  
2= A  
little/Fair  
  
3=Some/  
Good  
  
4= A lot/  
Very Good  
  
5=All the  
time  
/Excellent

Three (3) open-ended questions were also presented on the Family Survey. These questions asked families to expound upon aspects of their Community Collaborative involvement that they thought were most and least helpful, and any areas that they believed need to be changed. The general themes, categorized by question, are as follows:

- Question 4. What aspects of your experience with the Systems of Care did you find most helpful?
- Question 5. What aspects of your experience with the Systems of Care did you find least helpful?
- Question 6. What aspects of your experience with the Systems of Care would you change?

Most families were pleased with the assistance they received through the Community Collaboratives, often extending praise to their Care Coordinator and Family Advocate. These surveys indicated that the basic principles of the system of care philosophy were being adhered to in most instances and that based upon the services received families would recommend it to a friend needing this level of support.

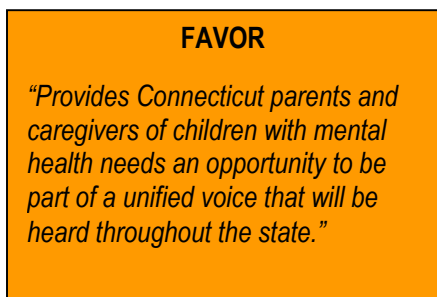
Instances in which families expressed dissatisfaction typically concerned waitlists and unavailability of community services. Such responses suggest that families may be confused about the role of the Care Coordinator and that of the Community Collaborative, attributing to them purview in area that are well outside their control. This is further supported by the manner in which many families completed the surveys, often identifying the Collaborative by a discernable, but wrong name. It appears that the Collaboratives need to better clarify their role and that of the Care Coordinator and Family Advocate to families.

Regular receipt of family satisfaction information is an important next step. As noted above, fewer than 30 surveys were received out of 432 families who have received Care Coordination during SFY 2002. Therefore, we only received feedback from a small number of families, and do not have satisfaction information for families from all the Collaboratives. The Quality Assurance Committee for Care Coordination is in the process of devising recommendations on this area. Determination of the survey distribution, receipt mechanisms and availability in multiple languages will need to occur to support the availability of broad family satisfaction data.

### Statewide Family Advocacy Network

As of October 1, 2001, the Department entered into contract with a consortium of family advocacy organizations. This contract was developed to support the development of a statewide family advocacy network to operate in partnership with families caring for children and youth with a SED. This service has been structured to emphasize empowerment, cultural competency, family strengths, parent/consumer leadership and self-determination. The emerging network, known as FAVOR (Family Advocacy Organization for Children) is creating local outlets where families can gain skills to advocate for their children and youth and access to other, quality and responsive support.

Figure 11. FAVOR's Charge



The goals of the family advocacy service are:

- To empower families through education and support such that they are enabled to take a lead role in the planning and delivery of their children's behavioral health treatment and receive the skills and encouragement required to ensure that they or their children with SED have a primary role in local and statewide activities and initiatives concerning the children's behavioral health system;
- To provide support to families whose children with serious emotional disturbance;
- To share information with families that will help in identifying and accessing available services;
- To ensure family participation in treatment planning for their child;
- To advocate with public policy makers and leaders for policies, procedures laws and sufficient funding to address the needs of children with serious emotional disturbance and their families; and
- To assist families in forming support groups in their communities.

Table 10. FAVOR Consortium

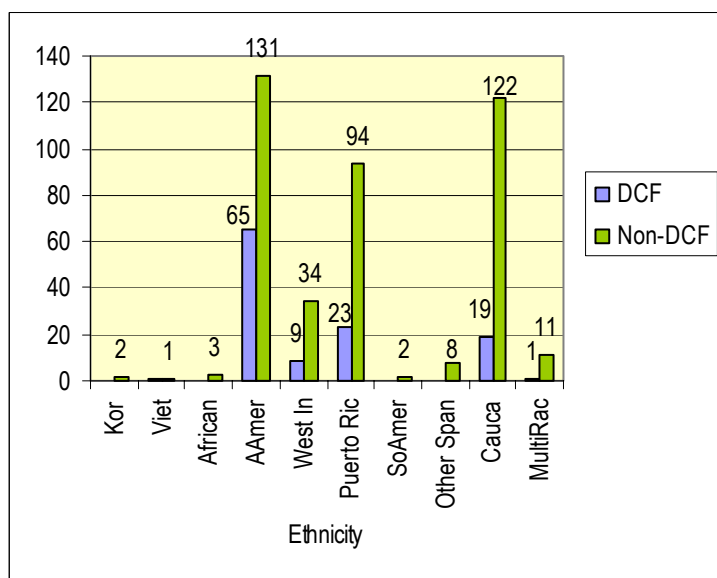
Agency
FAVOR
Padres Abriendo Puertas
African Caribbean American Parents of Children with Disabilities
Families United for Children's NAMI-CT

During FFY 2002, the Department of Children and Families funded the development of a statewide Family Advocacy network. Through a consortium application that included four community advocacy organizations (i.e., Padres Abriendo Puertas, African American Parents of Children with Disabilities, Families United for Children's Mental Health and NAMI of CT), the consolidated entity known as FAVOR has emerged.

FAVOR, the acronym for **Families AdVocacy ORganization** for Children, identifies as its primary purpose to "foster the strengthening and expansion of the children's mental health family movement in Connecticut." It spouses the following mission:

*Help improve mental health services for children with serious emotional disorders through Connecticut by increasing the availability, accessibility, cultural competence and quality of mental health services through Family Advocacy.*

The four agencies that are part of the FAVOR consortium have engaged in a number of activities to support the enhancement of the family involvement in the children's behavioral health care system. Generally, there are monthly educational forums and support groups hosted by FAVOR members in various parts of the state. Over the course of nearly 12 months, over 25 supports groups were convened in Spanish. Over 240 persons self-identified as being of Hispanic descent participated in a FAVOR support group.



**Figure 12. Families served by FAVOR: Face-to-Face**

The existence of FAVOR has considerably and positively advanced Connecticut's Family Advocacy movement. Through FAVOR's network, DCF funding supported 11 families' participation in the national, biennial System of Care of Care Technical Institutes held in Washington, DC. In addition, FAVOR will be assisting with the KidCare evaluation sub-study pertaining to Family Satisfaction with Care Coordination. Working with HSRI, caregivers will be trained and paid to engage in telephone interviews with families who have received Care Coordination through the Community Collaboratives. These results will be compiled and analyzed to dovetail with the broader KidCare

evaluation. The formal usage of parents in the KidCare evaluation process marks an important watershed in the state's family advocacy movement. In past Status Report's strategies to foster meaningful family involvement have been articulated, but it has only been within the last year or two in which the activities within the KidCare reform resonant with the commitment towards truly partnering with parents.

### Family Advocacy

Family Advocate positions have been dedicated to each DCF region and collaborative in the state. Parents who have successfully navigated the service system on behalf of their own children fill these positions. These advocates are available to partner with parents as they devise their family's Individual Service Plan and support families through empathetic listening and mentoring. The advocates also help providers see

problems and issues through the eyes of the family, thereby aiding in the development and provision of family friendly services.

The mission of Family Advocates is to assist, support, inform, and provide direct advocacy to families of children with serious emotional disturbances. The Family Advocate works with individual families by providing support, education and advocacy. They participate in activities that support the inclusion of family members in the planning, decision-making, and the implementation of services to children/youth with SED. Family advocates provide technical assistance and consultation to local System of Care Community Collaboratives in the areas of family support and advocacy, sensitivity to the needs of families, and strategies to promote proactive involvement of families at all levels of the children's behavioral health system. They also assist families in the development and/or expansion of parent support groups within the local communities.

**Table 11. Direct Family Advocates**

ADVOCATE	COMMUNITIES SERVED
Shari Bieber	Greater Bridgeport Area
Virginia Delmonaco	Greater Norwalk and Stamford Area
Barbara Coppola	Greater New Haven Area
VACANT	Middlesex and Meriden/Wallingford Area
Kathleen Carrier	New London Area
Tonya Long	Willimantic Area
Pamela Scott-Ashe	Hartford Area
VACANT	Greater Hartford/North Central Area
Barbara Patrick	Greater Waterbury Area
Linda Tucker	Greater Danbury Area

The advocacy program helps fill an immense service void and helps define system needs. While volunteer advocates are necessary to ensure that all families have access to a parent experienced in finding services for a child with serious emotional disturbance, Connecticut's full-time salaried advocates are essential to the local Community Collaboratives.

During FFY 2002, the Advocates served over 290 families, 188 of whom were new, unduplicated clients. This is a decrease over last year, but reflects deliberate and concerted efforts to align the direct, Family Advocacy program with the receipt of Level III Care Coordination. Previously, Family Advocacy could occur absent Care Coordination services. It was realized; however, that under such arrangements Family Advocates were forced to serve in a care coordination capacity. In addition, there was not an efficient gate-keeping mechanism to regulate the Family Advocate's client load size. Due to the demand for this service, both from families receiving services through the Community Collaboratives, and families outside the Collaboratives, the Family Advocates were being barraged with referrals. The few changes that have been instituted this past year, have regulated some of the demand, and allow the Advocates to concentrate on fewer clients. This does not; however, mitigate the need for additional protocols and capacity expansion to further support the valuable work of the Family Advocates.

In particular, the significant increase in Care Coordinators is a salient factor that has warranted review of the practices for this service. At present, the need and desire for a direct Family Advocate will outpace the service's current capacity. Dialogue about how Care Coordinators, through their supervisor, can prioritize and effectively gate-keep multiple requests for a limited service. Through the continued growth of FAVOR, it is expected that increased Family Advocacy capacity will occur. In the interim, until there have been significant capacity expansion for this needed service, there are challenges that must be addressed.

As with Care Coordination, activities to standardize this service and enhance the knowledge base of the Family Advocates are occurring. Practice Standards for Family Advocacy are in development. These Practice Standards will explicate the expectation for family advocacy and provide guidance on a number of essential aspects of this service (e.g., length of service, prioritization of referrals, etc.). Parallel to the development of the Practice Standards is creating a uniform referral document and standard releases. The documents created by the Quality Assurance subcommittee for Care Coordination will be used as the models. In addition, under the statewide Family Advocacy network umbrella training opportunities for the

Family Advocates and FAVOR Support Managers are being created. In particular, the Connecticut Legal Rights Project has a sub-contract through FAVOR that will provide advocacy training during FFY 2003. These trainings are intended to broaden advocacy competencies and aid seasoned advocates in developing the capacity to become topical area experts. (e.g., legislative process, policy development, etc.)

## **DATA COLLECTION**

Data collection has been an area in which the Department has infused significant resources over the past years. Last year, the advent of the Uniform Client Record (UCR) for the Systems of Care marked a watershed in the Department's data collection process. The use of this UCR and its attending monthly reporting requirements contextualized the Departments next steps in implementing a web-based data collection system for its behavioral health services. The data collection for the Care Coordination programs for the System of Care paved the way for comprehensive, client level data reporting, in which we could begin to track youth across community collaboratives. The new generation of reporting that the Department has embraced will allow it to view children's service profile more holistically and better support, positive individual child and family outcomes. The Department views the process in which the UCR and resulting data collection protocols were developed as solid practice. The UCR and the data reporting tools were created over the course of a year with participation from parents, care coordinators, community providers, family advocates, state agencies, a local university, and regional and statewide DCF staff.

The next important step in the data collection and management effort is the dissemination process. Creating regular, core reports that are easily understood and widely available to the community will be essential to desired service accountability and to support the Community Collaboratives in their work of identifying needs and making recommendations to improve outcomes for the children and families that they serve. Similar to the processes that were employed to secure buy-in for the data elements and collection protocols, this backend component of information management must include input from parents and providers to ensure broad utility of the data.

## **EDUCATION SYSTEMS & COMMUNITY COLLABORATIVES**

DCF and SDE have partnered to convene a Task Force that will address issues concerning education and children's mental health. The membership of this group draws upon participants from urban, rural and suburban school districts to allow for statewide educational needs to be represented (See Figure13) The objectives of the Task Force are as follows:

- Establish a basic framework for school involvement
- Plan a series of regional interagency forum/workshops at which to present this framework and discuss related issues.
- Consider the need for, and make recommendations concerning, the establishment of an advisory group concerning education and children's mental health, to collaborate with and make recommendations to state agencies and statewide initiatives.

During FFY 2002, this TaskForce facilitated the convening of six (6) educational forums across the state to promote school districts' understanding of and participation in System of Care Community Collaborative. A total of 363 people attended these meeting, with 179 of those attendees being school personnel. The forums were full day meetings held each of Connecticut's regional districts (i.e., ACES, CES, LEARN, EastConn, EdConnection and CREC). The work of the TaskForce and the dialogue that emerged from the forums was well received. It has been proposed that this task force become a standing committee convened by the State Department of Education entitled Education and Behavioral Health Committee with the goal of promoting the behavioral and social-emotional well-being of children and youth with particular attend to school involvement in the children's mental health system.



Connecticut's outreach to the schools is congruent with national efforts. Literature supports the importance of partnering with the education systems to develop a share agenda on children's mental health. Collaboration with the schools is particularly crucial in meeting the system of care principles of creating an infrastructure that supports early intervention and prevention services for children. A strong connection with the local education agencies should aid in providing children with a comprehensive array of community-based intervention, in the normative school setting.

### COMMUNITY COLLABORATIVE TRAINING

Last year, survey respondents expressed lack of training as a pressing need. In response to this need, DCF again contracted with CHDI to assist in identifying national experts to create a state of the art training curriculum. During

FFY 2001, a multidisciplinary steering committee facilitated by CHDI, including constituency groups with central office and national experts from the Human Service Collaborative devised a training curriculum for the KidCare initiative. The now termed, *KidCare Training Institute* provides communities with a 4-day training program to enhance participants' knowledge of the System of Care approach to behavioral health service delivery. Using parents, providers and DCF staff as trainers, approximately 1000 individuals have become educated in the philosophy and tenets that are integral to KidCare.

KidCare will be provided to all DCF staff, including its top management level personnel. A KidCare executive training was recently provided and included representation from agency staff Executive Directors and DCF's Bureau Chiefs and Commissioners. This important training, which is provided at no cost to participants, is facilitating the broad-based service delivery paradigm shift that has been viewed as crucial to supporting the culturally competent, family driven approach that KidCare espouses. A Spanish version of this curriculum has also been developed to encourage participation from Connecticut's Latino communities.

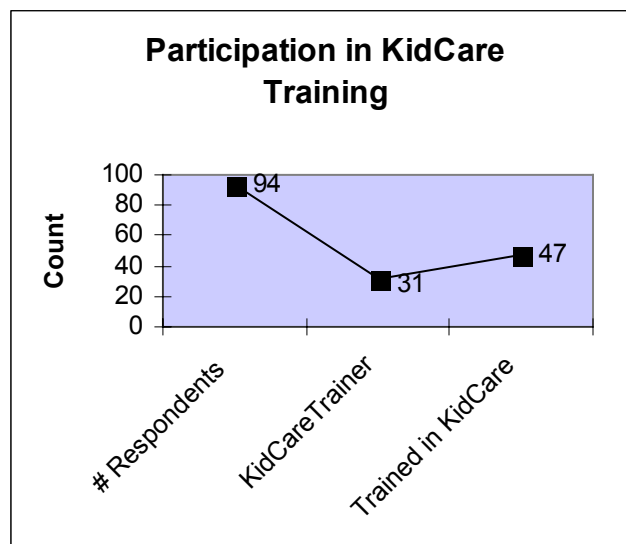
KidCare will be provided to all DCF staff, including its top management level personnel. A KidCare executive training was recently provided and included representation from agency staff Executive Directors and DCF's Bureau Chiefs and Commissioners, as well as the Commissioner of DSS..

Community Collaborative members have availed themselves of the KidCare training. A number of survey respondents indicated that members of their collaboratives had taken the training. Fifty-one percent (51%) of the Status Report survey respondents identified themselves as having taken the KidCare Training, with forty percent (40%) of the respondents identified as a KidCare trainer.

Figure 13: Education Task Force Membership

ConnCASE (special education/pupil services director)  
Connecticut Parent Advocacy Center  
State Department of Education  
Department of Children and Families  
Department of Social Services  
CABE (Board of Education Member)  
CAPSEF (Private special education facilities)  
CAPSS/CAUS (Superintendent)  
RESC (Regional Educational Service Center)  
SERC  
Principal  
School Guidance Counselor  
School Nurse  
School Psychologist  
School Social Worker  
Teacher

Figure 14. Survey Respondent Participation



A number of states across the nation have requested copies of the KidCare Training curriculum. In fact, representative from Connecticut, including a parent and the DCF Training Institute Coordinator, were selected to present at the esteemed national System of Care conference held in Washington, DC this past summer. A parent, who serves as a KidCare trainer, was also sent to a National Association of State Mental Health Program Director's (NASMHPD) conference in New Mexico to serve as a co-presenter on this curriculum and training process.

As noted earlier, a Pre-Service Training Curriculum has been developed for the Care Coordinators. Additional training opportunities are being developed for SFY 2003 to target not only Care Coordinators, but also Family Advocates and other service providers. The DCF Mental Health Division, Quality Assurance Committee and the Multiculturalism Committee are devising training plans to more extensively address essential elements of the children's behavioral health system paradigm.

Presently, Collaboratives seem to want training relating to accessing certain services and benefits (e.g., HUSKY A & B) and improving service quality (e.g., Cultural Competency). Also, there seems to be an articulated need for a routinized mechanism to share information. Based upon survey responses and anecdotal information, complementary training, such as team building and meeting facilitation might be areas of benefit to the collaboratives; particularly to aid the integration of new members into long standing collaboratives.

### **SALIENT ACHIEVEMENTS**

During FFY 2002, a number of successes have been realized under KidCare and through the Community Collaboratives. Individual Collaboratives and regions have engaged in numerous activities to promote and improve behavioral health services for children and their families. A number of these achievements are listed under the Exemplary Practices section of this Status Report. Some of the additional, salient accomplishments of 2002 are as follows:

- Execution of Memorandum of Understanding between DCF, Department of Social Services and Department Health and Addiction Services for the purpose of the joint administration of an integrated behavioral health delivery system (CTBHP)
- Enhancement of parent's and caregiver's opportunities to participate in the planning and development of the state's behavioral health service reform through the provision of stipends funded through the Mental Health Block Grant. Stipends have been offered to assist families with transportation, childcare and other related expenses that have in the past hindered their ability to attend planning and service development meetings
- Completion of A Report to the Connecticut General Assembly titled *Developing An Integrated System for Financing and Delivering Public Behavioral Health Services For Children and Adults in Connecticut*
- Development of KidCare Workgroups that are comprised of parents, providers, state agencies and DCF staff to develop recommendation to guide the planning and implementation of the KidCare reform
- Appropriation of over \$14 million, annualized, to enhance the service array within the KidCare continuum including the following:
- Expansion and enhancement of Care Coordination and Emergency Mobile (EMS) service by \$3,000,000 and \$7,000,000, respectively

- Emergency Mobile Services: Eleven (11) Emergency Mobile Service programs were developed. These programs will assist families during the psychiatric crisis of their youngster. The EMS programs are also available to provide crisis intervention at schools, upon authorization of a student's parent
  - Care Coordination: Forty-three (43) Care Coordination positions have been added in Connecticut to service children with multiple system involvement through the Community Collaboratives. These new positions will bring the total of Level II Care Coordinators to sixty (60) statewide.
- Technical assistance meeting regarding flexible funding contracting was held with David Ziska, a fiscal manager from Indiana's Behavioral Health Choice system of care initiative
- Finalization of DCF Voluntary Services policy to provide services for children or youths requiring community-based treatment or temporary residential or other out of home placement who might otherwise be committed as neglected, uncared for, or dependent. This program is designed to encourage the preservation and enhancement of family relationships and the continuing rights and responsibilities of parents even though limited financial resources prevent them from providing the required care and treatment for their child
- Creation of the Connecticut Center for Effective Practice through a collaboration with CHDI, DCF, Yale and the University of Connecticut to encourage and assist in the promulgation of evidenced-based practices
- Release of a Request For Information (RFI) pertaining to current practices and the typical range of administrative fees. The State may use the information in developing their managed behavioral health program design and in estimating associated administrative fees
- Development of contract boilerplates for Care Coordination, EMS, Intensive In-home Services and Therapeutic Mentoring to better ensure consistent and uniform service delivery
- Service expansion through the release of Request For Proposals (RFP's) for Flexible Funding to aid Systems of Care in creative and innovative service provision, creation of Early Childhood Mental Health Consultation Services, and programming to provide early, school-based mental health intervention for children in grades K-12
- Members of the Quality Assurance Sub-Committee of the Children's Planning Council selected to present at the annual System of Care Research Conference in Tampa, Florida
- Trainers from the KidCare Training Institute selected to present at biennial, System of Care Training Institute in Washington, DC
- Forums held in each of DCF's region's to facilitate dialogue and increased linkage between the education system and the System of Care Community Collaboratives
- DCF was awarded a Strengthening Communities grant from the Center of Substance Abuse Treatment (CSAT) for the Hartford Youth project. This grant is for \$750,000 dollars per year, for five years. The project will enhance the community-based treatment system through outreach, using evidenced based treatment models of MST, Multi-Dimensional Family Therapy and Cognitive Behavioral and Motivational Enhancement Therapy.

- The Department is in the process of finalizing its contract and RFP policies. These policies have been updated to include language and expectations that are congruent with the tenets of KidCare and will support the provision of culturally appropriate services.
- An evaluation of the KidCare system is occurring concurrent with its implementation. The Department has contract with the Human Services Research Institute and the Technical Assistance Center to complete these process, system and outcome evaluations.
- KidCare Kickoffs- Five KidCare kickoff celebrations were held across the state. These kickoffs marked an opportunity for DCF, parents, Providers, legislators, state agencies and other interested participants joined to officially launch the KidCare initiative in their communities.
- KidCare WorkGroups- Six (6) KidCare Workgroups were convened during SFY 2002. These workgroup which typically consisted of parents, providers, DCF Central and Regional Office staff, and other state agency personnel, were instrumental in refining structural elements of the KidCare reform.
- Data system- The Department shares a Data Infrastructure Grant (DIG) with the Department of Mental Health and Addiction Services to support compliance with federal Uniform Data Reporting Requirements. The Department has been reviewing the variables and measures of its behavioral health programs to ensure adherence with the federal expectation. An important step in this compliance has been the creation of a full electronic data reporting system for EMS and Care Coordination. This new data system marks the beginning of a comprehensive data management process in which client's behavioral health service profile can be collected, unduplicated, across program types.
- Residential RFA- An Request For Application (RFA) was released in late spring of this year. This RFA sought proposals to develop alternative residential options for 6 populations:
  1. Female youth, adjudicated as delinquent with significant behavioral health treatment needs.
  2. Gender specific services for youth 13-17 years of age with Co-occurring disorders with developmental issues and behavioral difficulties and needing an intensive level of intervention.
  3. Gender specific services for youth, age 17-22, transitioning to adult services provided by the Department of Mental Retardation or the Department of Mental Health and Addiction Services.
  4. Gender specific services for children and youth who demonstrate a range of high-risk behaviors concurrent with complex developmental and mental health service needs. Children to be served include those who are with or without cognitive/intellectual deficits, potential of criminal involvement and who have:
    - A history of severely aggressive behaviors
    - Demonstrated problem sexual behavior
    - Recent or repeat psychiatric hospitalizations
    - Recent thoughts or behaviors that are self-injurious or harmful to themselves and others

- A history of multiple, failed residential placements
  - Previous fire setting activity
5. Gender specific services for DCF committed youth (abuse/neglect/uncared for) ages 16-20 who would thrive in a small congregate care living arrangement with a 24/7 level of supervision and support services to develop the skills and abilities necessary for self-reliance as the youth move from substitute care to Independent Living in the community.
  6. Gender specific for children ages 5-12 who exhibit a range of behavioral difficulties and who need a stable secure living arrangement while their permanency plan is being implemented.
- In-Home Services- Each region has begun or finalized contract negotiations for Intensive In-Home Services. This service category, based upon evidence-based models, most notably Yale University's Intensive In-Home Child and Adolescent Program (IICAP), will offer families the opportunity to receive clinical services in their home environment.
  - Federal Mental Health Block Grant Site Visit- The Department underwent a review by CMHS of its behavioral health system. DCF received a very favorable report, with the national evaluators noting the tremendous work that Connecticut has done to improve children's behavioral health service since the last site visit of over five years ago.
  - Hosting Federal CMHS System of Care Demonstration Grant Conference- Connecticut was the site was the national October 2001 meeting of federal demonstration grants recipients. DCF mental health division staff presented at this conference on the topic of Connecticut's response to the events of September 11.
  - Federal Demonstration Grant Application- The Department, in partnership with the Bridgeport Public Schools, the United Way of Eastern Fairfield County, Families United for Children's Mental Health, the Bridgeport Child Advocacy Center and the Greater Bridgeport System of Care, applied and received a 9.5 million dollar system of care demonstration grant. This 6-year project would develop a school-based system of care
  - Re-constitution of CBHAC Multiculturalism Committee- The CBHAC Multiculturalism Committee was reinitiated during SFY 2002. This Committee has identified federal funds to support regional, community initiatives through the Systems of Care to promote cultural competency.

## BEST PRACTICES

The array of services under KidCare will assist with abatement of gridlock and limited capacity. As KidCare moves into its final stages of implementation, Community Collaboratives continue to engage in creative practices to supplement the current service continuum for children with complex behavioral health needs and their families. The ninety-six (96) Status Report surveys reveal that the vast majority of Collaboratives have adopted activities that exemplify the best qualities of a community approach and interagency coordination. The Best Practices for Community Collaboratives evidenced in 2002 were as follows:

- Community Collaborative Recognition Breakfast
- Development of a Parent Support Group
- Community Collaborative Open House
- Outreach to Courts about System of Care approach
- Convening Focus Groups to identify community needs

- Establishing a Community Collaborative Booth at community events
- Community Outreach, Informational and Legislative Breakfasts
- Interagency Management Team Development event
- Creation of Community Collaborative subcommittees
- Community Collaborative website
- Team building retreat for Collaborative members
- Newspaper articles on Community Collaboratives' activities
- Use of non-traditional settings for Collaborative meetings (e.g., church, fire station)
- Collaboration between Community Collaboratives with respect to Request For Proposal (RFP) application
- Use of membership dues to support flexible funding
- Development of standing agenda items for Community Resource Committee meetings (e.g., membership expansion, service utilization, needs, gaps, barriers to service, etc.)
- Development of Community Collaborative brochures (included bi-lingual)
- Identification of funds to engage in wraparound programming (e.g., funding camp for children with SED)
- Partnering with community stakeholders to better meet children and families' complex needs (e.g., business, churches, etc.)
- Sending birthday and holiday cards to families receiving Level III Care Coordination
- Organizing fundraising activities to support flexible funding
- Outreach to a local print company to get free publication of Community Collaborative material
- Applying for Community Foundation Grants
- Providing stipends to parents to aid in their participation in Community Collaboratives
- Creating specialized recreation programs for children with SED
- Holding a service provider fair

## **FUTURE DIRECTIONS**

As the Community Collaboratives mature, many of the issues that were present in past years have changed. The areas of improvement for Collaborative Collaboratives continue to mature congruently with the evolution of these complex care systems. Last year's Status Report indicated that Collaboratives were still grappling with fundamental issues of Practice Standards compliance. While there are pockets where limited areas of Practice Standards adherence remains a problem, most Collaboratives report needing technical assistance about how they can best effect the expectations articulated under Connecticut's System of Care model and their prospective role under KidCare. The final incarnation of the KidCare reform will undoubtedly define the ultimate duties and responsibilities of the various tiers of the Community Collaborative, and structural enhancements of the Community Collaboratives will aid them in supporting the KidCare initiative.

There were a number of consistent themes presented in the Status Report Surveys that spoke to next steps. Also, the System of Care design workgroup under KidCare, which included participation from Providers, Families, Family Advocates, DCF Regional and Central Office Staff, convened during 2002, also identified a number of issues that must inform the continued maturation of the Collaboratives. Some of the areas identified as requiring further exploration and explication are as follows:

- Defining Community Collaborative membership versus participation
- Supporting greater Parent involvement on the CRC and IMT levels
- Ensuring consistent attendance at the CRC level
- Facilitating greater Collaborative membership by non-traditional providers (e.g., housing, community-action agencies, and early childhood agencies.)
- Operationalizing many elements of the Practice Standards
- Creating sustainable cultural competence agenda

- Strategic information sharing for Collaborative members

Current documentation articulating the architecture of KidCare, identified technical assistance needs, and evident variances in many Collaboratives' defined charge suggest that additional guidance with respect to key aspects of Community Collaboration must occur. Complementing KidCare, possible future directions for the Community Collaborative include the following:

- Bylaws: The existence of bylaws individualized for each Collaborative might be beneficial. These bylaws could address important standard areas such as membership, attendance; voting, Request For Proposal (RFP) application and support. The issue of membership (rather than participation) is particularly critical as it impacts much of the work and function of the Community Collaboratives. Discussion with the Regional DCF Systems Coordinators suggests that the concept of membership and participation may be interchangeable for some Collaboratives. While this issue may seem to be one of semantics, it is concretely important if Collaboratives have not solidified an operational definition for membership. This difference is greatly important in situations where an RFP requires an applicant agency to be a member of the local Collaborative in which their service proposes to cover. This is also of impact where voting on issues is required. Failing a concrete definition of membership, participants who only partake in team members when a specific decision-making matter is presented can potentially controvert the will of a Collaborative.
- Annual Workplans: It may be helpful for each Community Collaborative to create annual strategic works plan. The most advance Collaboratives in Connecticut develop workplans to define their priorities and activities for the coming year. These Collaboratives use their workplan to guide the work of their subcommittees and measure their achievements. Collaboratives lacking such a workplan seem to display greater confusion about and wider variance in Collaborative members' knowledge of their role and relevant, community advancing activities.
- Annual needs assessments: The localized nature of community collaboratives poises them to engage in critical needs assessments. Using the multiple perspectives and linkages that exist from the collaborative's membership, these consortiums seem best able to collect and analyze community level data about service barriers, gaps and needs.
- Core Agenda: The establishment of standing, core agenda items may prove constructive in assisting the Collaboratives with their duties. Mature Collaborative again evidence that the forming of practices that focus their efforts and ensure standard membership information access aid them in improving care for children with SED and their families. It may be beneficial for all Collaboratives at the CRC to ensure that updates on Care Coordination utilization, referrals, aggregated demographic information, waitlist, key service availability (e.g., Extended Day Treatment, Respite, In Home services, Family Advocacy and EMS) regularly occur. Those Collaboratives that have set agenda items seem to have more active CRC and CRC subcommittees. Their CRC and CRC subcommittees use these updates to inform the activities s in which they engage.
- Community Collaborative Certification. This suggestion will require much further discussion and refinement. It is clear that under KidCare there will be a single, consolidated mechanism to access core and enhanced services, including Care Coordination. Concomitantly, an organized method of determining who can make application for the complement of KidCare services must exist. Absent such a controlled approach, disordered engagement of the KidCare utilization management agent will likely ensue. The system must have a clear means of determining the community entities that will be allowed to have a formal nexus with the KidCare administrative service organization. The concept of certifying Collaboratives such that they are ordained to have such a formal recognition is being

considered. The specific elements of a Community Collaborative certification would need to be fleshed out. Certainly, the CBHAC's Quality Assurance community would need to be integrally involved in this matter.

- **Leadership:** Formal and informal leadership of the Collaboratives has perennially been identified as a challenge facing some Community Collaboratives. The issue seems to range from one end of the spectrum to another (e.g., overly controlling leadership versus no clear leadership). The development of bylaws that address membership, roles, referral prioritization, data dissemination and chairmanship, might assist with resolving this issue. In addition, the institution of a practice of identifying parents to serve as Collaborative chairs and co-chairs might contribute to a more balanced direction of the work of these teams.
- **Collaborative Support positions:** The Community Collaboratives are fortunate to have designated DCF Regional Systems of Care Coordinator positions. These positions are important to providing the Collaboratives with information exchange, technical assistance and advice concerning their compliance with the KidCare model and Practice Standards. Due to the growing number of Community Collaboratives, and the increasing labor-intensive work of these bodies, and the potential conflicts of interest that fund raising activities might pose for the Systems Coordinators, another dedicated position might be beneficial. It is envisioned that these positions would be responsible for assisting the Collaboratives with the development of annual workplans, organizing and coordinating Community Collaborative outreach efforts, serving as staff to Collaborative subcommittees, and leading fundraising endeavors (e.g., grant-writing).
- **Peer Technical Assistance and Cross-Collaborative Team Building:** Opportunities for all members of the local Collaboratives to meet, network and share information are not routinely available. Regular occasions where the Collaboratives can meet to exchange best practices and receive technical assistance from one another are important learning and team building opportunities.
- **Peer and Self-Fidelity Assessment:** The System of Care Framework Matrix that was presented in this document offers a means of conceptualizing and determining system level fidelity to this community wrap-around model. Formal use of this matrix to evaluate Collaborative's adherence to and operationalization of the domains within the framework appears to be an important next step. Through peer and self-assessment, utilizing agreed upon indicators, each Collaborative can be evaluated to determine their level of fidelity to the principles and values of the system of care approach. This type of assessment would seem to assist the collaboratives in developing an annual strategic workplan.
- **Social Marketing Plan:** Many Collaboratives report difficulty attracting and sustaining participation from non-traditional service organizations, most particular providers of recreational programming. The Community Collaboratives note that non-traditional providers may attend a handful of meetings, but often discontinue participation remarking that they are unsure of what they might contribute to the collaborative process, or what they can hope to gain by becoming a member. Through the development of strategic material that is targeted to non-traditional entities (e.g., community agency, businesses, churches, etc.), and specifically addresses the concerns that these providers express, the Collaborative may be able to secure broader membership. In addition, a formal social marketing plan might assist Collaboratives with having prepared brochures and other material that explain this community initiative to potential funding sources (e.g., foundation).



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